



Australian Government
Department of Health and Aged Care

How Accreditation Practices Impact Building a Non-General Practice Rural Specialist Medical Workforce



 APPENDICES

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Title: How Accreditation Practices Impact Building a Non-General Practice Rural Specialist Medical Workforce

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Acronyms

AC	Accreditation Committee	ATM	Advanced Training Module
ACD	Australasian College of Dermatologists	AOA	Australian Orthopaedic Association
ACEM	Australasian College of Emergency Medicine	BEA	Board of Education and Assessment
ACRRM	Australian College of Rural and Remote Medicine	BEO	Branch Education Officer
ADF	Australian Defence Force	BiGS	Australian Board in General Surgery
AFRM	Australasian Faculty of Rehabilitation Medicine	BPT	Basic Physician Training
AHMAC	Australian Health Ministers' Advisory Council	BSET	Board of Surgical Education and Training
Ahpra	Australian Health Practitioner Regulation Authority	BTC	Branch Training Committee
AMACDT	Australian Medical Association Council of Doctors in Training	CAO	Chief Accreditation Officer
AMC	Australian Medical Council	CCA	College Committee for Accreditation
ANZAPS	Australian and New Zealand Association of Paediatric Surgeons	CEC	College Education Committee
ANZCA	Australian and New Zealand College of Anaesthetists	CFT	Committee for Training
ANZICS	Australian and New Zealand Intensive Care Society	CICM	The College of Intensive Care Medicine Australia and New Zealand
ANZSCTS	Australian and New Zealand Society of Cardiac and Thoracic Surgeons	COI	Conflict of Interest
ANZSVS	Australian and New Zealand Society for Vascular Surgery	COE	Council of Education
APSS	Assessments of Procedural and Surgical Skills	CMO	Career Medical Officers
ARC	Accreditation Review Committee	CPD	Continuing Professional Development
ASOHNs	Australian Society of Otolaryngology Head and Neck Surgery	CPMC	Council of Presidents of Medical Colleges
ASPS	Australian Society of Plastic Surgeons	CRETc	Clinical Radiology Education and Training Committee
		CRM	Customer Relationship Management
		CS	Clinical Supervisor
		D&P	Developmental and Psychosocial
		DOD	Director of Department



Appendices

DOHAC	Department of Health and Aged Care	FRANZCO	Fellow of the Royal Australian and New Zealand College of Ophthalmologists
DOT	Director of Training	FRANZCOG	Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists
DPE	Director of Physician Education	FRANZCR	Fellow of the Royal Australian and New Zealand College of Radiologists
EAG	Expert Advisory Group	FRCPA	Fellow of the Royal College of Pathologists Australasia
EAP	Employee Assistance Program	FPM	Faculty of Pain Medicine
ED	Emergency Department	FTE	Full Time Equivalent
EEMC	Education Executive Management Committee	GSA	General Surgeons Australia
EMC	Emergency Medicine Certificate	HAC	Hospital Accreditation Committee
EMD	Emergency Medicine Diploma	HAS	Hospital Accreditation System
EMAD	Emergency Medicine Advanced Diploma	HDS	Hospital Data Sheet
EMET	Emergency Medicine Education and Training Program	HETI	Health Education and Training Institute
EPA	Entrustable Professional Activity	ICU	Intensive Care Unit
ESO	Education Support Officer	IHCA	In-Hospital Clinical Assessment
ETC	Education and Training Committee	IANZ	International Accreditation New Zealand
EOI	Expression of Interest	IRTP	Integrated Rural Training Pipeline
FACD	Fellow of the Australasian College of Dermatologists	ITP	Integrated Training Program
FACEM	Fellow of the Australasian College for Emergency Medicine	JCT	Jurisdictional Coordinator of Training
FANZCA	Fellow of the Australian and New Zealand College of Anaesthetists	JMO	Junior Medical Officers
FCICM	Fellow of the College of Intensive Care Medicine Australia and New Zealand	LAN	Local Area Network
FEC	Formal Education Course	LGC	Local Governance Committee
FRACMA	Fellow of the Royal Australasian College of Medical Administrators	LHD	Local Health District
FRACP	Fellow of the Royal Australasian College of Physicians	LHN	Local Health Network
FRACS	Fellow of the Royal Australasian College of Surgeons	MBA	Medical Board of Australia
		MCNZ	Medical Council of New Zealand

MDANZ	Medical Deans Australia and New Zealand	RANZCP	Royal Australian and New Zealand College of Psychiatrists
MM	Modified Monash (Model)	RANZCR	Royal Australian and New Zealand College of Radiologists
NATA	National Association of Testing Authorities	RCPA	Royal College of Pathologists Australasia
NGC	Network Governance Committee	RO	Radiation Oncologist
NICU	Neonatal Intensive Care Unit	ROETC	Radiation Oncology Education and Training Committee
NMWS	National Medical Workforce Strategy	ROTS	Rotational Supervisor
NSA	Neurosurgical Society of Australasia	RTH	Regional Training Hub
NSQHS	National Safety and Quality Health Service	SET	Surgical Education and Training Program
NTD	Network Training Director	SIMG	Specialist International Medical Graduate
NZTC	New Zealand Training Committee	SOT	Supervisors of Training
O&G	Obstetrics and Gynaecology	SRP	Section of Rural Psychiatry
OBCK	Ophthalmic Basic Competencies and Knowledge	SSP	Specialist Skills Placements
PGY	Post Graduate Year	SSU	Specialised Study Unit
PHO	Principal House Officer (also known as service or unaccredited registrar)	STP	Specialist Training Program (Commonwealth)
PHRM	Prehospital and Retrieval Medicine	TA	Training Accreditation
QEC	Qualification and Education Committee	TAC	Training Accreditation Committee
RACMA	Royal Australasian College of Medical Administrators	TAS	Training Accreditation System
RACP	Royal Australasian College of Physicians	TND	Training Network Director
RACS	Royal Australasian College of Surgeons	TPS	Trainee Portfolio System
RAG	Rural Advisory Group	USANZ	Urological Society of Australia and New Zealand
RANZCO	Royal Australian and New Zealand College of Ophthalmologists	VMO	Visiting Medical Officer
RANZCOG	Royal Australian and New Zealand College of Obstetricians and Gynaecologists	VTP	Vocational Training Program
		WAN	Wider Area Network
		WBA	Work Based Assessment



Appendix A: Australasian College of Dermatologists (ACD)

The Australasian College of Dermatologists (ACD) is the peak medical college accredited by the Australian Medical Council (AMC) for the training and professional development of medical practitioners in the specialty of dermatology. The ACD provides authoritative information about dermatology to Government, the media, other health professionals, and the general public.¹

The ACD is accredited by AMC until 31 March 2022, and is the only specialist medical college in Australia accredited by Tertiary Education Quality Standards Agency as a Higher Education Provider. The accredited courses include Master of Dermatology, Master of Cosmetic Dermatology, Graduate Diploma of Cosmetic Dermatology, and Graduate Certificate of Cosmetic Dermatology.

Membership of the ACD includes 643 Fellows, with 75 non-practising and 112 Trainees.²

College Governance

The ACD is governed by a Board of Directors who are elected, appointed and co-opted by the ACD membership. The ACD Board meets regularly to discuss matters of governance and items that are brought to their attention via the State Faculty Chairs or the various Board related committees. In association with the College Management Committee, the Board sets the five year rolling Strategic Plan which is updated annually. There are five faculties:

- NSW (including ACT)
- Victoria (including Tasmania)
- Queensland
- South Australia (including Northern Territory)
- Western Australia

All committees which have an education brief, report to the Academic Standards Committee, whose Chair sits on the Board of Directors.³

Strategic Plan 2020–2023

The ACD's *Strategic Plan 2020–2023* includes the goal 'To lead skin health education and training: Our goal is to be the unifying leader in skin health education and training for specialist dermatologists, other health professionals, students, communities and patients.'

One of the steps to achieve that will be by: 'Helping to address inequitable access to dermatology care in regional, rural and remote areas by exploring innovative methods for delivery of education and training.'⁴

1 <https://www.dermcoll.edu.au/about>

2 <https://www.dermcoll.edu.au/wp-content/uploads/2020/06/AnnualReport2019.pdf>

3 <https://www.dermcoll.edu.au/about/our-people/governance/>

4 ACD Strategic Plan 2020–2023
<https://www.dermcoll.edu.au/wp-content/uploads/2020/02/DERM0898-ACD-STRATEGIC-PLAN.pdf>

Accreditation Governance

The National Accreditation Committee undertakes accreditation of training sites including assessments against the accreditation standards. The National Accreditation Committee reports and makes accreditation recommendations to the Academic Standards Committee. The Academic Standards Committee reports to the ACD Board.

Under its Charter, the Academic Standards Committee oversees the ACD education and training programs with respect to strategic alignment, policy implementation, development/ implementation and evaluation of teaching, learning and assessment and research standards and accreditation of training posts and sites. The membership includes the Dean of Education, Chairs of related subcommittees, a representative of the Trainee Representative Committee, a Fellow with educational expertise and two external members with education expertise.⁵

The National Accreditation Committee also has a Charter that includes membership, requirements, representation from each faculty, and a yearly work plan for the committee. At the end of each year the report is completed and reported to the Academic Standards Committee. Faculties nominate representatives to committee for a period of two or three years. Trainees may participate but have no voting rights, they are ex-officio members.

The National Accreditation Committee meets twice a year, one meeting in February/March via teleconference and one meeting face to face at the Annual Scientific Forum in May. Other meetings may occur as needed via teleconference. A community member has not yet been included in the committee.

As the ACD is a small college, most Fellows know each other so there are potential biases that need to be addressed and actively managed when Fellows undertake ACD college activities. As part of its governance of accreditation, the ACD employs a number of mechanisms to ensure balanced, considered, objective and consistent accreditation assessments, recommendations and outcomes.

Representation on accreditation sub-committees is required to be from outside of faculty under assessment to minimise bias and Conflict of Interest (COI). The ACD ensures that committees rotate so that membership is refreshed with new ideas and suggestions to improve college activities. This can potentially disrupt consistency, however, there are guidelines and a clear process for undertaking accreditation activity. Support from ACD staff is essential to ensure adherence to guidelines and policy and ensure that the accreditation process is undertaken in a timely and appropriate manner.

COI in accreditation is managed through an ACD Code of Conduct and COI Policy that applies college-wide for any education related committees. Some subjectivity will occur as accreditation is a peer review activity and people will bring their own experiences and biases to the assessments. Specific management of COI within accreditation practices is managed by the ACD through the structured process administered by dedicated ACD accreditation staff.

5 AMC Accreditation Report: The Training and Education Programs of the Australasian College of Dermatologists, https://www.amc.org.au/wp-content/uploads/accreditation_recognition/specialist_edu_and_training/report/2018_-_dermatologists_report.pdf



Specialty Training Program

Training Context

Trainees in the program undertake four years of practical training in accredited clinical settings under the supervision of practicing dermatologists.⁶

The State Faculties, in conjunction with the Director of Training in each state oversee the implementation of the national program in their state. Trainees are rotated through different positions in the course of the four years and have experience in city, rural, large and small hospital practice. There is the opportunity to apply to train overseas for one year.⁶

In addition to on-the-job training, trainees have access to the National Skin School, a series of webinars run by dermatologists, on-line modules which complement the training program, the Annual Scientific Meeting, and to special events run by each State Faculty. International Medical Graduates who have been accepted into the training program for upskilling purposes have on-line modules, breakfasts and meetings, and specific support tailor made to their needs.⁶

Upon successful completion of the training course, graduands will receive their Fellow of the ACD (FACD) at the conferring ceremony at the Annual Scientific Meeting in May of each year. Majority of dermatologists work in private practice, but also provide their services to hospitals and volunteer in remote areas of Australia. A number continue in research and academia.⁶

The ACD reported that 80–90% of specialist dermatologists are in private practice. The 2018 AMC report stated that '80% of the College's training sites are public hospitals with the remainder being private hospitals, skin and cancer foundations and private practices...a particular rotation may involve attending multiple sites (clinics) each week, while employed by one organisation'.⁷ Simple cases are mainly accessed by trainees through private practice with complex cases more prevalent in public hospitals.

There are between 17–22 new trainees per annum with 50 per cent split of training across the public and private sector being ideal for a dermatology trainee to complete specialty training requirements. Trainees can only spend up to 12 months in private practice. Rotations vary between six, 12 and 24 months in duration, depending on training sites. Each training position must form part of a Training Facility Network. Trainee rotations in WA are usually three months, sometimes six or 12 months. Directors of Training and Heads of Departments organise the rotations and will ensure that trainees meet training requirements in their training so provide targeted access to specific training experiences.

Rural training posts are rare in dermatology and in some faculties, rural sites are serviced via a Visiting Medical Officer (VMO) model, in some cases trainees are able to attend these visits if supported by employer and specialist. NSW has the most rural posts with rural clinics often in private practice e.g. Bowral Dermatology in NSW. A new rural site has commenced in Townsville in 2021.

6 <https://www.dermcoll.edu.au/for-health-professionals/becoming-a-dermatologist/the-training-program/>

7 AMC Accreditation Report: The Training and Education Programs of the Australasian College of Dermatologists, https://www.amc.org.au/wp-content/uploads/accreditation_recognition/specialist_edu_and_training/report/2018_-_dermatologists_report.pdf

Trainees have an online portfolio incorporating procedures log, online training modules, mid- and end-of-year assessment, exams, work based assessments, head of department sign off and other documents. Procedures could be signed off at different stages (in line with competency) as there is significant variation as to where and when a trainee will have access to a case or procedure in the faculty rotations.

Logbook data is not used in an accreditation assessment, however, should an issue be raised, the logbook data may be used as part of the investigation to verify and/or validate claims.

Training Networks and Trainee Allocations

Training networks occur within the faculties but trainees can cross borders depending on preferences and ranking.

Allocation of trainees to training posts is determined by the learning needs of the trainee, availability of sites, and stage of training. Placements of trainees can be negotiated between faculties and trainees can apply to move. Some faculties have very limited positions available.

Supervision

The ACD is reliant on Fellows who are willing to supervise specialist training. Not all Fellows engage in specialty training post-Fellowship.

In the case of models of supervision, supervision by someone who is not a FACD does occur for particular procedures. Plastic Surgeons or other surgeons are able to sign off on certain procedures. This is an arrangement with the supervisor of dermatology training and the non-FACD within the jurisdictional area or health service, not formalised by the ACD and is reliant on local relationships.

Supervisors are generally always FACD, however, there are trainees in Singapore and the UK who are supervised by non-FACDs. There is one FACD in the UK who supports specialty training locally in London. These non-Fellows of the ACD are still Dermatologists.

Remote supervision has been considered in the past, but is currently not supported. However, it can often occur that some trainees will be remotely supervised in some way, such as the supervisor is onsite but is not in the clinic. The supervisor will come in at the end of the clinic to check on the trainee. Tele-dermatology is currently being supported in Queensland for the Tiwi Islands whereby a remote trainee will review the General Practitioner (GP) work. Remote supervision is not something that is formally supported yet, however, there is some appetite for the ACD to consider further.



Accreditation Framework

The ACD accredits both dermatology and Mohs Micrographic Surgery positions, each with a specific set of accreditation standards. The Mohs program requires a qualified FACD to undertake a further one to two years (full or part time) of intensive specialist training in an accredited training post. This project focuses only on pre-Fellowship vocational training and therefore will not cover the accreditation of Mohs Micrographic Surgery positions.

Training positions are accredited in order to:

- Ensure that all trainees/ candidates are provided with a learning environment which will educate and train competent dermatologists, as defined by the dermatology curriculum, and/or competent Mohs specialists as defined by the Mohs surgery curriculum.
- Maintain a consistent level of education and training in every accredited post.
- Gather feedback from key stakeholders to continually improve all aspects of the training programs.

The National Accreditation Committee is responsible for accrediting all training positions and consists of a Fellow from each state, including a Mohs Surgery Committee representative, and a member from the Trainee Representative committee.⁸

The ACD accredits training positions within a faculty incorporating a different number of sites per faculty and different training models. Faculties are accredited every five years with the accreditation assessment team incorporating a visit to each site which includes meeting with supervisors and trainees separately at each site. Only one faculty is accredited per annum. Each training position has a unique college identifier.

Australian Accredited Training Positions

There are 43 accredited sites in Australia across public, private and rural sectors for the delivery of dermatology specialty training,⁹ as shown in Table 1 below.

Each faculty is different and incorporates different training models. For example, in WA there is one employer and trainees will move around different clinics at different sites throughout a working week to gain exposure to case mix and appropriate numbers of cases. Often one hospital won't run more than one clinic a week for dermatology in WA.

In QLD and NSW trainees may be at the one site for up to 12 months and do some private practice work as part of training.

8 <https://www.dermcoll.edu.au/for-health-professionals/becoming-a-dermatologist/accreditation-training-positions/>

9 <https://www.dermcoll.edu.au/for-health-professionals/becoming-a-dermatologist/accreditation-training-positions/>

Table 1. Number of Accredited Dermatology Training Sites – August 2020

Training Facility Network / Faculty	Number of Accredited Sites
Queensland	7
New South Wales	15
Australian Capital Territory	1
Victoria	12
Northern Territory	1
South Australia	3
Western Australia	4

There is flexibility within the training program to allow faculties to determine the most appropriate way to deliver training and rotational model within the faculty. Trainees may apply to undertake training in another faculty.

ACD Accreditation Standards for Training Positions¹⁰

The ACD sets criteria that outline the minimum requirements for accreditation of a Training Facility Network. There are mandatory criteria, available on the website, that are considered necessary to support specialty training and training facility networks must meet these criteria for full accreditation to be granted. If a training facility network is unable to meet the mandatory criteria, the ACD will recommend accreditation with provisos or conditions with set timeframes to meet accreditation standards. The ACD Accreditation Standards for Training Positions is at Appendix A1.

When the ACD is undertaking an assessment, a three-point rating scale is used against each standard determined by assessment across five variables.

Rating Scale:

- Below Accreditation Standard
- Expected Accreditation Standard
- Above Accreditation Standard

Variables:

- Strength of Evidence – verbal and documentary
- Consistency of application – whether standard is met in all areas at all times
- Maintenance over time – outcomes over time
- Sustainability infrastructure – level and sophistication of infrastructure to support training outcomes
- Quality Improvement – presence of quality improvement measures

Some flexibility is applied in the accreditation practices of the ACD to enable exposure for trainees to different health care settings and clinical cases. The ACD encourages all training posts and training facility networks to progress towards meeting all criteria and may incorporate recommendations in accreditation outcomes to achieve this.

¹⁰ Accreditation Standards for Training Positions, 2017, <https://www.dermcoll.edu.au/wp-content/uploads/170614AccredStandardsTrainingPositionsV3.pdf>



Appendices

Accreditation Process

Establishment of a new post

Applications to establish new posts can be submitted at any time. Any new post must be part of an existing faculty and must meet all the accreditation standards in a desktop assessment to be assigned provisional accreditation for 12 months. During the 12 month period there is monitoring via teleconference meeting at six months and at nine months a site visit is scheduled to validate and confirm the continuation of accreditation before the expiry of the 12 month provisional accreditation. During the monitoring period, case mix, case load, supervision and trainee wellbeing and support are reviewed using a structured set of questions. If the training post continues to meet the accreditation standards throughout the provisional accreditation period and satisfies the National Accreditation Committee that it can continue to meet the requirements for accreditation, accreditation will be confirmed by the ACD.

If during the provisional accreditation period the training post does not meet requirements for accreditation, the ACD, through the National Accreditation Committee, can alter the accreditation decision to either add conditions or provisos or withdraw accreditation altogether.

Re-accreditation of a training post and faculty

Every five years an accredited training post and training facility network (faculty) is reviewed. Every training post within a faculty is required to submit completed documents by a predetermined date to support the re-accreditation assessment. This may vary from state to state depending on how many training posts being re-accredited. The process provides an opportunity to bring all members of the training facility network together to review its support of specialty training. The ACD will visit every site in the faculty and speak to trainees, supervisors and others in the organisation that support specialty dermatology training. The assessment of accreditation will follow the same process as for a new training post and cover assessment against all standards.

Accreditation Teams

Accreditation teams are members of the National Accreditation Committee consisting of two FACD and an ACD staff member who assists the National Accreditation Committee. The ACD is working towards the regular inclusion of a trainee representative on panels.

During an accreditation assessment, whether via teleconference, video conference or site visit, the accreditation team will ensure they speak with all parties involved in specialist training including the trainee, supervisors, heads of departments and director of training. At times, a trainee has been involved in the review process, however, this has not yet been formalised.

A set process and structure has been established for accreditation assessment teams to follow with set questions allowing participants the flexibility to give feedback outside of the scope of questions. All teams use the same set of questions to construct the accreditation report.

Once a report is written it and approved by the relevant members of the ACD, it is released to the training site and the faculty.

Monitoring of Accredited Training Posts¹¹

Accreditation with Provisos

Accreditation with provisos is assigned to a training post that has been accredited or re-accredited and did not meet all of the accreditation requirements. Review checks occur over a set period of time by an accreditation inspection team. This status can be granted at the end of the unsatisfactory completion of a full accreditation period or provisional accreditation period.

There are proviso review checks at every three to six month mark incorporating reporting templates, teleconference meetings and site inspections (as required).

Once the training post has achieved compliance with all provisos, the National Accreditation Committee will assign full accreditation. Should the training post remain non-compliant, the committee can re-assess the position and amend the accreditation status to conditional accreditation.

Accreditation with Conditions

A training post is assigned conditional accreditation for a period defined by the National Accreditation Committee when it fails to comply with provisos and meet the minimum requirements for accreditation.

The ACD inspection team and Chair of the National Accreditation Committee undertakes regular reviews with the training facility with the course of action determined on a case-by-case basis.

At the end of a period of conditional accreditation, the training post will either meet the minimum requirements for accreditation, be assigned its original accreditation status or fail to meet requirements. At this point, the National Accreditation Committee can either re-assess the accreditation status of a training post or withdraw accreditation.

The ACD is looking at introducing annual reviews of sites through a structured process of reporting to keep the college informed of any changes at accredited sites. Currently monitoring is ad hoc and relies on ACD members advising the ACD when an event occurs that impacts specialty training.

Events or changes to training posts that impact on accreditation and potentially trigger re-accreditation include changes to networks, change of rurality, change of focus of private practice, service delivery, infrastructure, supervision and training positions such as case mix, clinics and case load. Changes to the support of trainees such as location, study resources, welfare will also trigger a review of accreditation.

11 Accreditation Reviews and Outcomes, Guidelines Version 2,
<https://www.dermcoll.edu.au/wp-content/uploads/2014/05/ACCREDITATION-REVIEWS-AND-OUTCOMESv2.pdf>



Appendices

Review of Accreditation Framework

The ACD reviews the accreditation framework as required rather than at set intervals. The main drivers of change in the ACD accreditation framework, whether it be governance, standards or process are specialty training program changes, curriculum changes, regulatory changes and trainee welfare.

Changes in accreditation have evolved over time to meet the changing specialist training environment. Changes have been made to improve support for supervisors, trainees and to promote increased transparency, consistency, expertise and responsiveness in accreditation.

These changes include increased review of accredited sites, introduction of trainees to the accreditation governance and assessment process and ensuring external members are on accreditation panels.

An increased focus on trainee wellbeing has also included private conversations with trainees as part of the assessment process to capture feedback that trainees may not wish to share with supervisors or the facility. Accreditation panels now also include regular review of trainee rosters.

Supervisor training has been introduced by the ACD to improve its support of supervisors of specialty training.

Survey tools have been employed by the ACD to seek feedback on an annual basis on training experience and supervision as part of the specialist training program. This information also contributes to the review of accreditation of training posts as well as the overall framework.

Accreditation Data Management

The ACD collects and maintains accreditation data via electronic and manual (or paper-based) methods. Electronically the college is currently using Microsoft Excel and Access programs that enable reporting.

Rural and Regional College Activities

Following on from the 6th Rural Dermatology Meeting in September 2019, the ACD's Rural and Regional Services Committee has been tasked with collating opinions and solutions that can be enacted to address the supply of services and workforce maldistribution.¹²

Selection of trainees with rurality is in development. A member of the Rural and Regional Committee is on the Selection Committee. A component on rurality is included in the CV application process.

¹² The Mole, Issue 122, Spring 2019, Australasian College of Dermatologists, <https://www.dermcoll.edu.au/wp-content/uploads/2019/10/TheMole122spring2019.pdf>

Appendix A1: ACD Accreditation Standards Training Positions

Below is an outline of the ACD Accreditation Standards for Training Positions. Full details are available on the ACD website.¹³

ACD Standards for Accreditation of College Training Positions

STANDARD 1

Education and Training

Educational and clinical training experiences that enable trainees attaining competencies of the ACD specialist training program including:

- 1.1. Schedule of learning experiences
- 1.2. General Dermatology Clinics
- 1.3. Surgical Sessions
- 1.4. Patient Case Mix
- 1.5. Dermatopathology
- 1.6. In Training Assessment
- 1.7. Inpatient Exposure
- 1.8. Research
- 1.9. Meetings and Conferences

STANDARD 2

Supervision and Coordination

The provision of effective supervision and coordination to support trainees in acquiring the necessary skills, behaviours and knowledge to become a competent dermatologist, including the increasing degree of responsibility as competency is achieved:

- 2.1. Supervisor of Training
- 2.2. Clinical Supervisors
- 2.3. Feedback and Responsibility
- 2.4. Training Facility Network

STANDARD 3

Equipment, Facilities and Clinical Support

Access to equipment, facilities and clinical support that contribute to enabling delivery of patient care by trainees across the curriculum:

- 3.1. Equipment
- 3.2. Supervision
- 3.3. Diagnostic laboratory services

STANDARD 4

Learning and Working Environment

An environment that fosters a commitment to learning and a structure that delivers and monitors safe practice.

- 4.1. Educational Services
- 4.2. Orientation
- 4.3. General Education
- 4.4. Trainee Wellbeing
- 4.5. Supervision support
- 4.6. Audit Program

¹³ Accreditation Standards for Training Positions, 2017, <https://www.dermcoll.edu.au/wp-content/uploads/170614AccredStandardsTrainingPositionsV3.pdf>



Appendix B: Australasian College for Emergency Medicine (ACEM)

The ACEM is the not-for-profit organisation responsible for training emergency physicians and advancement of professional standards in emergency medicine in Australia and New Zealand.¹⁴

The role of ACEM is to:

- Deliver specialist Emergency Medicine education and training for full Fellowship as well as a Certificate, Diploma and Advanced Diploma in Emergency Medicine, and the Diploma in Prehospital and Retrieval Medicine, including all relevant assessments.
- Maintain professional standards in training, including accreditation of Emergency Departments for Emergency Medicine Training.
- Advance professional standards in emergency medicine.
- Research and advocacy, including providing expert guidance and advice on policy to relevant bodies on matters relating to Emergency Medicine.
- Improve emergency medical education in rural and regional areas.
- Engaging in proactive discussions with jurisdictions and agencies in regard to complex matters such as workforce, as well as widening the membership of its entities to ensure that the necessary breadth of stakeholder input is available to enable informed decision-making.

ACEM represents nearly 3,500 members throughout Australia and New Zealand. The College also represents over 2,500 emergency medicine trainees. Membership categories include:

- Fellows of the Australasian College for Emergency Medicine (FACEMs)
- Certificants, Diplomates and Advanced Diplomates of Emergency Medicine
- Educational Affiliates
- Honorary Fellows
- Retired Fellows

The ACEM Board has a Strategic Plan for the 2019–2021 period that outlines a key focus by the College on complex workforce challenges and resource constraints, particularly in rural, remote and specialised practice.¹⁵ The ACEM Business Plan for 2019–2021¹⁶ operationalises the board's Strategic Plan. Under Strategic Priority 1: Education, 'ACEM will, with a focus on quality improvement, facilitate and support the education, training and CPD of emergency medicine professionals in a way that ensures the production of a high-quality workforce that meets the needs of the diverse populations in Australia and New Zealand'.¹⁷ This includes a review of the accreditation framework such as standards, regulations and processes that reflect changes in the Emergency Medicine specialty training program, curriculum and training support and resources such as IT systems and online learning.

¹⁴ <https://acem.org.au/Content-Sources/About>

¹⁵ ACEM Strategic Plan 2019–2021, The Next Phase, https://acem.org.au/getmedia/a52a56da-564b-4f87-99e3-872e1243105c/ACEM_Strategic-Plan_2019-2021

¹⁶ ACEM Business Plan 2019–2021, https://acem.org.au/getmedia/9ddb8159-312e-4cd4-972b-d92d91ca0b66/2019-2021-ACEM-Business-Plan_1Apr19

¹⁷ ACEM Business Plan 2019–2021, https://acem.org.au/getmedia/9ddb8159-312e-4cd4-972b-d92d91ca0b66/2019-2021-ACEM-Business-Plan_1Apr19

ACEM is accredited by the AMC until 31 March 2026.

College Governance

ACEM is governed by a Board that meets six times per year and face to face at the Annual General Meeting in November each year.

The ACEM Board consists of seven fellows, one trainee representative, two non-members and a community representative. The ACEM Board oversees committees, governing bodies and working/steering groups.

The Council of Education (COE), the educational governing body, via the Specialist Training and Assessment Committee, oversees the Accreditation Committee and all accreditation activities for ACEM, including any suggested changes to the accreditation framework and standards. Membership comprises of 15 people including board members such as the Immediate Past President, Censor-in-Chief, Deputy Censor-in-Chief, regional censors for each jurisdiction, a community representative and a trainee representative.

The Specialist Training and Assessment Committee has oversight of the FACEM Training Program including assessments, examinations, and accreditation of sites for training.

In early 2018, ACEM established the Trainee Selection and Workforce Planning Reference Group. The Reference Group is an advisory body to the ACEM Board tasked with development of strategic policy direction in the areas of the evolving emergency medicine workforce needs and jurisdictional priorities, as well as the selection of trainees for the FACEM Training Program.¹⁸

Accreditation Governance

The ACEM Accreditation Subcommittee is responsible for the accreditation of emergency departments (EDs), paediatric emergency departments and special skills placements, for the FACEM Training Program. Subcommittee members are required to participate in a number of inspections each year and meet three times per annum, one meeting face-to-face and two meetings via teleconference.

Any significant changes in accreditation are signed off by the COE. These then go to the ACEM Board for information, although this body could suggest further changes, if deemed necessary.

Under the Principles of Accreditation, ACEM will ensure that in the accreditation and re-accreditation of training sites, balanced and objective assessments are made against requirements set out in the FACEM Training Program Site Accreditation – Requirements¹⁹ documents. The process of accreditation is conducted in an open and accountable manner in accordance with college policies, regulations and guidelines and follows an ongoing process of review and continuous improvement to ensure sites are well-supported in meeting accreditation requirements.

Accreditation subcommittee and Panel of Inspectors members undertake annual training to update knowledge and skills to ensure consistency of assessment. There are also online modules to support accreditation training.

¹⁸ <https://acem.org.au/News/April-2018/Workforce-planning-top-of-the-agenda-at-ACEM.-Nati>

¹⁹ <https://acem.org.au/Content-Sources/Training/Training-site-accreditation>



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All requirements have suggested strategies of how a site can meet requirements and the subcommittee ensures consistency and balance in the final outcome. Inspectors who may need further guidance have access to a training webinar. ACEM is working towards developing more elearning modules for inspector training.

Inspections are conducted by members from the Panel of Inspectors, which is made up of Accreditation Subcommittee members, the Censor-in-Chief, Deputy Censor-in-Chief, Regional Censors (and Deputies) and other experienced accreditation inspectors appointed by the Accreditation Subcommittee.

ACEM has a set of detailed accreditation standards and requirements²⁰ which hospitals wishing to be accredited must meet. A completed application form demonstrating how the site meets each of these requirements must be submitted. ACEM offers the *AC550 FACEM Training Program Site Accreditation Process Guide*²¹ and a sample filled application form to assist with this and gives examples of evidence that a hospital can provide to demonstrate that they have met the standards. Full accreditation will only be granted after a site visit by members of the Accreditation Inspection Panel, who report and make recommendations to the Accreditation Subcommittee.

Inspection teams do not inform sites of inspection findings. The inspection team makes recommendations to the Accreditation Subcommittee who makes the final decision on the accreditation inspection outcome. Having ACEM staff on the inspection team and writing the report for all visits supports consistency. The lead inspector chairs the inspection and is from interstate and the second inspector is local to provide local knowledge.

If the Accreditation Subcommittee cannot reach a majority decision, the matter is referred to the Specialist Training and Assessment Committee. Recommendation for withdrawal of accreditation is referred directly to the Council of Education.

If a new site has had an application for accreditation rejected by the Subcommittee, ACEM will clearly articulate the reasons for the decision outlining criteria that needs to be met before a resubmission of application for accreditation can occur. Regional representatives from the Subcommittee are available to provide guidance and support to sites in relation to requirements. ACEM Regional Censors also assist health services experiencing difficulty with accreditation. Censors are members of the COE.

20 ACEM Accreditation Requirements AC549 v2,
https://acem.org.au/getmedia/003f59d2-b5c9-433f-9ff5-bb0843b2f950/AC549_1-6.aspx

21 FACEM Training Program Site Accreditation Process Guide, December 2021, AC550,
https://acem.org.au/getmedia/54966000-dbfd-44ce-aa19-8ae7e8f5cba5/AC550_1-5.aspx

Specialty Training Program

The Fellowship of the Australasian College for Emergency Medicine (FACEM) training program is a structured five-year training program, which includes satisfactory completion of:

- one year of Provisional Training
- four years of Advanced Training.

Provisional Training requirements:

- A minimum of six months Full-Time Equivalent (FTE) training in a single approved ED within a 12-month period. This must be completed within the first 12 months of commencing provisional training.
- A minimum of six months FTE training in other approved training (ED or non-ED).
- Minimum placement duration for Provisional Training is two months FTE at a single training site.
- Part-time training must meet minimum placement duration requirements and be undertaken at a minimum of 0.5 FTE of the full-time position.

Early (Stage 1) and Late Phase (Stages 2 and 3) Advanced Training requirements:

48 months training to include:

- A minimum of six months FTE in a major referral ED
- A minimum of six months FTE in urban district or rural/regional ED
- Early Phase: 12 months FTE in an accredited ED
- Late Phase: 18 months FTE in an accredited ED
- Critical Care: six months FTE in intensive care unit and/or Anaesthetics
- Non ED: six months FTE in an accredited Non-ED
- Discretionary: six months FTE in an accredited ED or Non-ED
- Minimum placement duration for Advanced Training is three months FTE at a single training site.

Trainees work in EDs in hospitals for the majority of their training and must also undertake training in anaesthesia and/or intensive care, as well as additional placements in non-emergency posts and/or areas of special skill, such as toxicology, retrieval, medical education, and research. A minimum of a three month rotation is required to count towards meeting training requirements and supervised practice.

Of the 30 FTE months of core emergency medicine training, at least 12 FTE months must be undertaken in an adult ED, at least six FTE months must be undertaken in an ED(s) in a major referral hospital and at least six FTE months must be undertaken in an ED(s) in an urban district hospital or a regional/rural base hospital.

Each ED training site is accredited a maximum amount of Advanced Training time (six, 12, 18 or 24 months).²²

The ACEM also offers training programs leading to the Emergency Medicine Certificate (EMC), Emergency Medicine Diploma (EMD) and Emergency Medicine Advanced Diploma (EMAD). ACEM recognises that many emergency departments in rural, regional and remote Australia are staffed by medical practitioners who have not undertaken ACEM's specialist emergency medicine training program, and that substantial emergency care is provided to the community by doctors who are not emergency medicine specialists. These programs play an increasingly important role in meeting the workforce needs in rural, regional and remote areas.

²² FACEM Training Handbook, January 2022,
https://acem.org.au/getmedia/5651dae4-bbf4-4a80-b68d-cd402912577b/FACEM_Training_Handbook_1-12-2



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Certificate (EMC), Diploma (EMD) and Advanced Diploma (EMAD) Training Programs in Emergency Medicine

The structure of the training programs follows a three-tiered format, with the Emergency Medicine Certificate (EMC), Emergency Medicine Diploma (EMD) and the Emergency Medicine Advanced Diploma (EMAD) as nested curricula; that is, the knowledge and skills of the three programs progressively build upon each other from one training program to the next. Each program requires a minimum of six months ED training time under the supervision of an approved supervisor.

The EMC is suited to and intended for doctors working in an emergency department with access to off-site advice and rapid access to on-site critical care support or as part of the team in an emergency department with senior assistance available on the floor when needed.

The EMD is suited to and intended for doctors working in an emergency department with access to offsite support, but without rapid access onsite critical care support or as part of the team in an emergency department where they are a senior decision maker (SDM).

The EMAD was introduced in 2021. It is suited to and intended for doctors providing clinical support to Emergency Medicine Certificate (EMC) and Emergency Medicine Diploma (EMD) qualified doctors and as a Director of a smaller Emergency Department (not accredited by ACEM for fellowship training) or working in an emergency department as a senior decision maker with the ability to be a part of the education and management team.

A new diploma training program for Prehospital and Retrieval Medicine (PHRM) was also launched in 2021. The diploma is aimed at trainees in their final years of specialty emergency medicine training and collaborates with other colleges such as Australian College of Rural and Remote Medicine (ACRRM).

Supervision

Mixed / Adult Only Emergency Departments must have FACEM supervisors. Paediatricians can supervise trainees in Paediatric Emergency Departments. Remote supervision is not acceptable.

In certain Specialist Skills Placements (SSP) terms, the supervisor can be a non-FACEM but are generally Fellows from the respective Colleges, for example, FANZCA, FCICM or FACRRM.

The biggest accreditation challenge for emergency medicine specialty training is the critical mass of supervisors and appropriate supervisor FTE for training. There may be sufficient FACEMs to support service delivery but not the critical mass for training. As a procedurally focussed college, it is currently not possible to provide supervision remotely.

Rotations and Allocations of Trainees

Trainees must be training in accredited positions for a minimum terms (two months for a Provisional trainee and three months for an Advanced Trainee) to count towards core ED training time. Sites in an accredited Emergency Medicine Training Network centralise recruitment and allocations of trainees throughout the training network. Metropolitan health services can support rural health services with provision of trainees in situations of high service demand. This may be for three or six months at a time.

Accreditation Framework

ACEM accredits both Adult and Paediatric Emergency Departments for the FACEM Training Program. ACEM designates Emergency Departments in the following categories:

- Major Referral (MM1)
- Urban District (MM2)
- Rural/Regional Hospital (MM3–7)

In addition, for the Advanced Training phase of the program, ACEM also accredits SSP to provide focussed non-ED training to a competence level equivalent to that described in Advanced Training.

ACEM accreditation 'seeks to ensure that defined minimum acceptable levels of training are provided at sites'.²⁰ ACEM accreditation also ensures that trainees and supervisors are provided with appropriate support and resources and assists accredited sites to understand their role in delivering quality, effective and supportive specialty emergency medicine training.

ACEM reviews the accreditation framework every three years and recently introduced new standards in 2017 that conform to the Australian Health Ministers Advisory Council and Health Workforce Principal Committee's Specialist Medical Training Sites Project. The accreditation framework involve a focus on training over service provision.

The accreditation framework, ACEM Accreditation Requirements for Emergency Medicine Training Providers, consists of three domains, eight standards, 15 criteria and 52 specific requirements.

- **Domains:** Goals of emergency medicine training
- **Standards:** Support each goal of emergency medicine training
- **Criteria:** Specific actions required to achieve each standard
- **Requirements:** Specific to accreditation as a provider of specialist emergency medicine training. The requirements are mandatory actions that support the criteria.

The accreditation requirements apply to Adult, Mixed and Paediatric Emergency Departments. In relation to Paediatric Emergency Medicine, ACEM and the Royal Australasian College of Physicians (RACP) contribute to the Joint Training Committee that works with the Accreditation Subcommittee on matters relating to the accreditation of Paediatric Emergency Departments.

ACEM has embedded the principles of continuous quality improvement in the accreditation framework in not only the assessment of sites but in collaboration with sites to achieve and maintain accreditation requirements over the accreditation cycle. Sites are required to undertake self-assessments against the accreditation requirements at the five year re-inspection. Sites are required to develop quality improvement plans when recommendations are made at inspections. ACEM reviews the quality improvement plans, and may instigate a focussed site visit out of cycle should a site not demonstrate sufficient progress towards meeting requirements.

Additionally, ACEM may initiate a focussed investigation (which may include a focussed site visit) of a site at any point within the five year cycle, in response to issues identified through the monitoring of accreditation conditions, the review of ACEM data, or other substantiated avenues.



Appendices

Accreditation Standards

The FACEM Training Program Site Accreditation document outlines all accreditation domains, standards, criteria and requirements against each criterion.²³ The guidelines provide the intent for each standards with suggested strategies and examples of evidence to comply with the standards and criteria. Further details are provided at Appendix B1.

Networks

The ACEM supports Emergency Medicine Training Networks which is a group of two or more accredited training sites that have formally agreed to provide a coordinated education and training program.

Under network arrangements, each site must contribute to education according to the level of accreditation with training to be delivered by FACEMS from each site. There is central coordination for recruitment and trainee allocation across the network. Trainees are not required to rotate to all sites within the network. Networked sites are accredited in the same year to ensure ongoing alignment for specialist training rotations and accreditation cycles.

Linked Accreditation

Smaller training sites can link with an accredited host training site to meet accreditation requirements that they otherwise would not meet as a stand-alone facility. The host training site provides support for education, training and other resources. Linked sites are only accredited for six months of specialty emergency medicine training.

Community Need

ACEM considers community need under its accreditation framework with a strong advocacy focus for community with smaller emergency departments (often rural emergency departments) having lesser supervision requirements and allowances for shared educational resources with the larger host hospital to enable these smaller departments to qualify as a training site.

Accreditation Cycle

The accreditation cycle is five years. During the accreditation cycle, ACEM monitors accredited sites via an annual census, trainee placement survey, examination report and Work Based Assessment (WBA) reports.

A review of accreditation can occur at any time during the five year cycle at either the request of the accredited training site or at the discretion of ACEM.

²³ <https://acem.org.au/Content-Sources/Training/Training-site-accreditation>

Provisional Accreditation

Health services who wish to become training organisations submit an application for accreditation to ACEM for assessment by the Accreditation Subcommittee against the accreditation requirements. This can be a health service that has never been accredited or a site that has previously lost accreditation.

The Subcommittee will determine if the application has 'Met', 'Partially Met' or 'Not Met' all of the requirements. If requirements are all either Met or Partially Met, the site will receive provisional accreditation.

For sites that have previously lost accreditation, the period of provisional accreditation, if approved by the Council of Education, will only be for six months. For new sites, the period of provisional accreditation will also be for six months.

Provisional accreditation is determined and communicated to the site within eight weeks of application. Once provisional accreditation is approved, the site has 12 months to appoint a trainee otherwise provisional accreditation will lapse and the site will be required to re-apply for accreditation.

A site inspection is conducted towards the end of a trainee's placement at the site to assess the site against requirements. Following a successful site visit, accreditation will be confirmed by the Subcommittee.

Accreditation Outcomes

Once accreditation is approved, ACEM communicates with health settings the outcome and specifies:

- Approval as either an Adult / Mixed ED, Paediatric ED or Emergency Medicine Training Network.
- The maximum amount of time a trainee can spend at the site.
- Specified number of trainees the site can support (where applicable).

Conditional Accreditation

In situations where sites receive conditional accreditation as they have either 'Not Met' or 'Partially Met' accreditation requirements, sites must submit a Quality Improvement Plan. The plan must identify remediation measures with progress updates within specific timeframes reported to the ACEM Accreditation Subcommittee. The normal period for sites to address the recommendations is six months or shorter, depending on the severity of the condition.

The Accreditation Subcommittee will determine if the site has satisfactorily met requirements to be accredited. In the case of a site that does not comply or meet requirements under the Quality Improvement Plan, the Subcommittee may decide on downgrading the accreditation. In the case of unsatisfactory progress towards conditions and a recommendation of withdrawal of accreditation, the COE will be required to make a determination.²⁴

²⁴ FACEM Training Program Site Accreditation Process Guide, December 2021, AC550, https://acem.org.au/getmedia/54966000-dbfd-44ce-aa19-8ae7e8f5cba5/AC550_1-5.aspx



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Accreditation Data Management

ACEM have moved to accepting applications for accreditation via email / online only. ACEM has a bespoke, purpose built accreditation database that links into the training program. It keeps records of accredited sites, outcomes of assessments, rotations and placements (particularly length of time of rotations). There is an exception reporting process where if a trainee works 12 months at a site accredited for only six months, they will only have six months of the term recognised towards their training requirements.

There are processes that facilitate internal profiling of sites, annual survey information including trainee and supervisor experience.

The system has monitoring capability and supports ACEM to oversee any accreditation conditions linked to milestone reporting by sites. There are various reporting functions, though IT support is required.

In line with the introduction of reviewed standards that were finalised in early 2020, ACEM is in the process of redeveloping the accreditation system.

Appendix B1: FACEM Training Program Site Accreditation

The table below outlines the Domains, Standards and Criterion required for emergency medicine accreditation. The full guidelines are available on the ACEM website.²⁵

Table 2. Domains, Standards and Criterion for FACEM Training Program Site Accreditation

Standards	Criterion		
Domain 1: Promotes the health, welfare and interests of trainees			
Standard 1.1 Governance, safety and quality assurance	Criterion 1.1.1 The training site has clear governance structures, which support: a) education and training, b) workplace health, safety and welfare of trainees, c) trainee participation in governance d) improved safety and quality	Criterion 1.1.2 Trainee management structures are effective	Criterion 1.1.3 There are appropriate quality assurances in place
Standard 1.2 Infrastructure, facilities and educational resources	Criterion 1.2.1 There are appropriate educational resources and these are available to trainees	Criterion 1.2.2 The training site provides a physical environment that supports trainees	
Domain 2: Ensures trainees have the appropriate knowledge, skills and supervision to deliver quality patient care			
Standard 2.1 Department specialist staffing and supervision	Criterion 2.1.1 There is appropriate staff to ensure effective supervision of trainees at all times	Criterion 2.1.2 Supervisory staff understand their roles and responsibilities and are supported in their supervisory roles	Criterion 2.1.3 The designated Director(s) of Emergency Training is supported in the role and is available to trainees
Standard 2.2 The provision of clinical experience and work is relevant	Criterion 2.2.1 The training site provides the appropriate breadth and volume of clinical experience		

²⁵ https://acem.org.au/getmedia/003f59d2-b5c9-433f-9ff5-bb0843b2f950/AC549_1-6.aspx



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Standards	Criterion	
Domain 3 – Supports a wide range of educational and training opportunities aligned to the Curriculum Framework requirements		
Standard 3.1 Education, training, teaching and learning opportunities	Criterion 3.1.1 Teaching and learning opportunities in the workplace are targeted and enable exposure to the breadth of experience in the learning environment	Criterion 3.1.2 Structured education programs and continuing medical education sessions are available to trainees
Standard 3.2 Multidisciplinary clinical support services and equipment	Criterion 3.2.1 Information on relevant supporting services and specialties to support the delivery of the specialty service	Criterion 3.2.2 Equipment is available to provide the specialty service
Standard 3.3 Research opportunities are promoted and facilitated	Criterion 3.3.1 The training site facilitates and supports specialty – specific research	
Standard 3.4 Accreditation by others where required	Criterion 3.4.1 The facility is accredited by other recognised accreditation bodies	

Appendix C: Australian and New Zealand College of Anaesthetists (ANZCA)

The Australian and New Zealand College of Anaesthetists (ANZCA) is the professional organisation for about 6400 specialist anaesthetists (Fellows) and 1500 anaesthetists in training (trainees).

ANZCA was formed in February 1992 after 40 years operating as a Faculty of Anaesthetists within the Royal Australasian College of Surgeons.

Its function is to cultivate and maintain the highest principles and standards in the training, practice and ethics of anaesthesia, perioperative medicine and pain medicine.

One of Australasia's largest specialist medical colleges, ANZCA, along with its Faculty of Pain Medicine (there are around 470 pain medicine fellows and 100 trainees), is responsible for the training, examination and specialist accreditation of anaesthetists and pain medicine specialists and for the standards of clinical practice in Australia and New Zealand. ANZCA also plays a significant role in the advancement of anaesthesia in south-east Asia and South Pacific island countries.

ANZCA's mission is 'to serve the community by fostering safety and high quality patient care in anaesthesia, perioperative medicine and pain medicine'.²⁶

From the mission flows three major objectives:

- To promote professional standards and patient safety in anaesthesia, perioperative medicine and pain medicine.
- To promote education in anaesthesia, perioperative medicine and pain management.
- To advance the science and practice of anaesthesia, perioperative medicine and pain management.

ANZCA is accredited by the AMC until 31 March 2023, following a request for an extension to its accreditation.²⁷ Although ANZCA submits progress reports to the AMC, ANZCA has not yet been fully assessed against the revised 2016 AMC standards.

Faculty of Pain Medicine

The Faculty of Pain Medicine (FPM) is a faculty of the Australian and New Zealand College of Anaesthetists and is the professional organisation for specialist pain medicine physicians (Fellows) and specialist pain medicine physicians in training (trainees). The Faculty is responsible for the training, examination and specialist accreditation of specialist pain medicine physicians and for the standards of clinical practice for pain medicine in Australia and New Zealand and reports to the ANZCA Council. Formed in 1998, the Faculty is the first multidisciplinary medical academy in the world to be devoted to education and training in pain medicine.

²⁶ <https://www.anzca.edu.au/about-us/our-culture/strategic-plan>

²⁷ <https://www.amc.org.au/australian-medical-council-accreditation-update-specialist-medical-colleges/>



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The Faculty of Pain Medicine arose out of collaboration between five participating bodies:

- The Australian and New Zealand College of Anaesthetists (ANZCA).
- The Royal Australasian College of Physicians (RACP)
- The Royal Australasian College of Surgeons (RACS)
- The Royal Australian and New Zealand College of Psychiatrists (RANZCP)
- The Australasian Faculty of Rehabilitation Medicine (AFRM) of the RACP.

The FPM has the Training Unit Accreditation Committee to implement and oversee the accreditation of multidisciplinary pain management training units for the core training stage on behalf of the FPM Board. This project did not meet with the FPM as Fellowship of the FFPM is a post-specialisation qualification in Australia and New Zealand.

College Governance

ANZCA is governed by the ANZCA Council, which sets the direction of ANZCA and ensures it achieves its objectives. The ANZCA Council reviews and approves the annual strategic plan and budget, and develops and monitors key performance indicators and other benchmarks. The ANZCA Council terms of reference describe the purpose, functions and workings of the council. The ANZCA Council can delegate responsibilities to its Executive Committee, other committees and management, but remains accountable for the actions of its delegates and the following:

- Setting strategy
- Reviewing and approving the annual budget
- Managing risk
- Cultivating and maintaining the highest principles and standards of practice of anaesthesia, intensive care and pain medicine
- Promoting the science and practice of anaesthesia, intensive care and pain medicine
- Monitoring the performance of the College against its financial benchmarks and strategic objectives.

The *ANZCA Strategic Plan 2018–2022*²⁸ outlines key emerging initiatives and activities under four main goals:

1. Leading professional identity and perioperative medicine
2. Growing lifelong education, training and professional support
3. Driving research and quality improvement
4. Supporting workforce and wellbeing

Strategic Goal 4 supports the 'sustainable growth of a diverse, high quality and healthy anaesthesia and pain medicine and staff workforce so all communities in Australia and New Zealand have access to high quality anaesthesia, pain medicine and perioperative services'²⁸.

In particular under 4.1, ANZCA is developing a rural, regional and remote workforce strategy incorporating government support programs, workforce planning, the development and implementation of a Rural GP Anaesthetist training pathway and rural Continuing Professional Development (CPD) training.

²⁸ <https://www.anzca.edu.au/about-us/our-culture/strategic-plan>

Underpinning this will be promotional activities in relation to the benefits and rewards of working in rural, regional and remote areas and support for pre and post vocational learning and professional development.

The ANZCA Council is assisted by the Board of the Faculty of Pain Medicine and several ANZCA committees. ANZCA's regional and national committees also play a role in implementing council directives.

ANZCA staff provide administrative, technical and management support, together with professional advice, to ANZCA councillors and its various boards and committees.

Accreditation Governance

The Education Executive Management Committee (EEMC) reports to ANZCA Council and oversees, guides and reports on ANZCA education activities and the operations of the Education Development and Evaluation Committee, the Training Accreditation Committee (TAC), Specialist International Medical Graduates (SIMGs) and the Trainee Committee.²⁹

The TAC reports to the ANZCA Council and it implements council policy in relation to the accreditation of approved training sites and rotational training programs in anaesthesia, in accordance with its terms of reference, noting that rotations are approved by the New Zealand National Committee and the Australian regional committees.³⁰

The TAC implements policy in relation to the accreditation of training sites, ensures the quality assurance of accreditation through the development of an accreditation framework including standards, procedures and documentation and oversees the accreditation of new sites, reaccreditation and conduct of accreditation site visits. The TAC makes accreditation recommendations to the EEMC for approval.

The TAC meets four times per annum face to face and via teleconference to consider all matters related to accreditation.

Membership is approved by the ANZCA Council and consists of a Chair, Deputy Chair, members, regional/national accreditation officers (representing jurisdictions) and trainee representation. Consideration is given to knowledge of College policies and accreditation practice, diversity in practice and geographical location; incorporating rural or regional representation is not formalised for the TAC. The TAC currently has a member from a rural location but this is not always the case.

ANZCA has a special interest group with rural fellows and members and all of the Regional committees have 'feed-in' rural members. Accreditation officers from each of the jurisdictions also sit on the jurisdictional (state) ANZCA Regional Committees.

29 Regulation 2 Committees of the ANZCA Council, <https://www.anzca.edu.au/getattachment/9d8dd78f-344b-40fc-92a1-6b25860b248d/Reg-2-Committees-of-ANZCA-Council#page>

30 Regulation 2 Committees of the ANZCA Council, <https://www.anzca.edu.au/getattachment/9d8dd78f-344b-40fc-92a1-6b25860b248d/Reg-2-Committees-of-ANZCA-Council#page>



Specialty Training Program

Anaesthetists spend at least seven years in postgraduate training. This includes two years of prevocational experience and five years in specialist anaesthesia training after graduating from medical school.

The training program is divided into four core units:

1. Introductory training – 26 weeks (max. 52 weeks)
2. Basic training – 78 weeks (max. 182 weeks) with primary examination
3. Advanced training – 104 weeks (max. 260 weeks) with final examination
4. Provisional fellowship training – 52 weeks (max. 104 weeks).

Trainees must complete each core unit before moving onto the next unit. Following the completion of all components of the program including training portfolio, a trainee will be awarded the Fellowship in Anaesthesia.

All training must be completed in accredited training sites that are part of an ANZCA rotational program.

ANZCA accredited sites are required to provide trainees with supervisors and tutors to support training and to implement the ANZCA curriculum in their hospital or other training site.

Supervision

A Head or Director of an ANZCA accredited training site or Supervisor of Training must be a Fellow of ANZCA. Heads or Directors are responsible for nominating supervisors of training and ensuring ongoing compliance with ANZCA accreditation standards.

Supervisors of Training (SOTs) are broadly responsible for anaesthesia training at each ANZCA accredited training site. They have a strong understanding of and experience in ANZCA activities. They oversee each trainee's clinical performance and confirm progression of trainees through the various stages of the training program. Depending on the demands of their workload, SOTs may also provide oversight to trainees from other colleges who are working in their department, although their primary responsibility is to ANZCA trainees'.³¹

The size of the training site will depend on the number of SOTs, a small site may have one and a larger site, more than one.

Someone who is providing clinical supervision of the workforce does not have to be a Fellow of the ANZCA (FANZCA). They can be a FANZCA, they could be someone who is recognised by the Australian Health Practitioner Regulation Agency (AHPRA) as a specialist anaesthetist, someone who has gone through an equivalent pathway. A clinical supervisor could be an SIMG who is substantially comparable in an approved program or someone who is on the ANZCA provisional fellowship program (final year of training), transition to specialist year or it could be someone who is providing clinical supervision of the workforce.

GP anaesthetists are not able to be the clinical supervisor for ANZCA trainees, however, they can be involved in facilitating tutorials.

³¹ ANZCA handbook for training, December 2021, v 2.5,
<http://www.anzca.edu.au/documents/training-accreditation-handbook.pdf>

To support trainees ANZCA also has Introductory Training Tutors, Clinical Fundamental Tutors, Education Officers, Departmental Scholar Role Tutor, Provisional Fellowship Supervisors and Specialised Study Unit (SSU) Supervisors. All must hold a FANZCA except SSU supervisors must hold a FANZCA or a comparable qualification acceptable to ANZCA Council, for example, an Intensive Care Medicine supervisor is the SSU supervisor for the intensive care medicine unit.

There are four levels of supervision recognised by ANZCA for anaesthesia trainees. As trainees progress through training they gain competence and transition through the levels of supervision to Level 4 at the point of the Provisional Fellowship year leading to the Fellowship Exam.

- **Level 1** – Supervisor rostered to supervise one trainee and is available solely to that trainee. This level is appropriate for any area of training where the trainee is unfamiliar. This is particularly important in Introductory Training, one-to-one teaching, feedback and learning new techniques.
- **Level 2** – Supervisor rostered to supervise two trainees who are undertaking clinical activities in close proximity to one another. The supervisor must be on site, fully conversant with the nature of the patients in both locations and able to provide one-to-one supervision of each trainee as appropriate.
- **Level 3** – The supervisor is available in the institution but is not exclusively available for a specific trainee.
- **Level 4** – The supervisor is not in the institution but is on call within reasonable travelling time (usually 30 minutes) and is exclusively rostered for the period in question. Consultation must be available at all times.

Rotations and Rotational Programs

A rotation is a group of ANZCA accredited departments that together are able to provide trainees with a comprehensive and integrated training experience covering all essential elements of the (specialty) training program.³²

All accredited training sites must be part of a rotational program and must work collaboratively with each training site in the rotational program to ensure appropriate allocation of trainees in line with training needs and requirements. All trainees in a rotational program are on the anaesthesia specialist training pathway.

Health services also employ 'independent' trainees to work in anaesthetic registrar positions (similar to unaccredited registrars) who are not on the anaesthesia specialist training pathway and not part of rotational programs. There are also Joint Consultative Committee on Anaesthesia trainees from RACGP and ACRRM who work alongside specialty rotational trainees in accredited training positions at accredited sites. In addition, some accredited positions will be allocated to other specialty trainees including trainees in intensive care and emergency medicine.

Rotational supervisors (ROTS) co-ordinate the training and rotation of ANZCA trainees among the various hospitals within their accredited rotation.³³ ROTs should have an understanding of the training needs of each trainee in the accredited rotation and the capability of each department within the accredited rotation to meet these needs. The reviews of rotations is carried out by the regions rather than through the central training and accreditation committee and reported to the TAC. The Queensland Rotational Committee has a representative from the Queensland Health Medical Workforce Unit on the committee.

³² ANZCA handbook for accreditation, December 2021 v2.2,
<http://www.anzca.edu.au/documents/anzca-handbook-for-accreditation-v1-0.pdf>

³³ ANZCA handbook for training, December 2021 v 2.5,
<https://www.anzca.edu.au/resources/all-handbooks-and-curriculums/anzca-training-handbook>



Accreditation Framework

ANZCA accredits training sites across Australia, New Zealand and regions in Asia and supports exposure of trainees to a broad range of training environments to ensure that as specialist anaesthetists, they can practice in a broad range of health settings. These training sites can be hospital anaesthesia departments, satellite hospitals or campuses that are recognised for appropriate breadth and depth of workplace experiential training and appropriate supervision in accordance with the accreditation standards. Approved Vocational Training can only be undertaken in accredited training sites. Accreditation applies to training sites and training sites determine the optimum number of trainees per site. The number of trainees per site may also be determined by service requirement and hospital funding availability.

All accredited sites must notify the TAC of any changes that may impact specialist training. Changes that may impact specialist training include, change in supervisor or supervision arrangements, case mix, case load and changes in staffing in the department.

ANZCA indirectly accredits intensive care units accredited by the College of Intensive Care Medicine (CICM) in intensive care medicine.

The accreditation cycle is five years for each accredited site with a duration of accreditation determined. Each site may be accredited for specific training durations across introductory, basic and advanced training of 26 weeks (six months), 52 weeks (12 months), 104 weeks (two years) or 156 weeks (three years) with the ability for a site to extend training time by the same amounts as accredited, where required.³⁴

The greater the number of training requirements a training site can meet, the greater the amount of time the training site is accredited for. For example, a training site that 'can meet the training requirements of one complete specialised study unit, or a greater number of partial specialised study units (with fractions adding up to at least one in total), that each trainee in the department can achieve, may be eligible for up to 26 weeks accreditation'.³⁴

Accreditation Standards

ANZCA has seven accreditation standards with set criteria under each standard and minimum requirements for each criteria.³ Details of the standards can be found at Appendix C1. The full ANZCA Handbook for Accreditation can be found on the ANZCA website.³⁴

Accredited Training Sites

Training sites include major teaching hospitals, non-teaching hospitals, smaller public hospitals, private hospitals and co-located public / private hospitals. Independent accreditation applies to both public major teaching hospitals and private hospitals. Private hospitals need to provide additional specific assurances to ANZCA in relation to employment conditions and award arrangements, indemnity, patient consent and the ability to engage in 'hands on' experience, not just as an observer.

³⁴ ANZCA handbook for accreditation, December 2021, V2.2,
<https://www.anzca.edu.au/resources/all-handbooks-and-curriculums/anzca-handbook-for-accreditation.aspx>

Satellite Accreditation

Satellite training sites are departments or smaller sites that partner with larger hospitals to offer specific training opportunities, for example, specialised study units, private hospital or rural and regional experience. Satellite accreditation must be linked to a partner site to achieve compliance with the accreditation standards.

Examples of satellite arrangements include:

- Co-located public and private hospitals whereby trainees rotate between sites on a list-by-list basis for subspecialty experience. The supervisor of training will be located at the larger partner hospital.
- Public non-teaching and major teaching hospital whereby trainees rotate to the satellite site (non-teaching hospital) for three months of basic anaesthesia training with a supervisor located at both sites.
- Public hospital and major teaching hospital in same metropolitan area whereby trainees rotate on a daily basis for specific subspecialty experiences. A supervisor of training is located at the major teaching hospital and a specialised study unit supervisor is at the satellite hospital.

Additional Campus

Some sites or departments will have additional campuses which are run by the base hospital under the same governance structure by the same staff, for example, a public hospital may hire a theatre at a private hospital to undertake additional work. In such a case, the additional campus can only be accredited if the main hospital and department is already accredited by ANZCA and the accredited hospital must submit the application for additional campus accreditation.

For an additional campus to be accredited, trainees must spend at least 10% or less of their training time at the site, Level 1 supervision must be available, the site must be accredited under the National Safety and Quality Health Service (NSQHS) Standards and hold appropriate indemnity.

Accreditation Assessments

The accreditation team is responsible for ANZCA onsite accreditation assessments of all health services that have applied to be newly accredited, are due for re-accreditation as part of the five year cycle or 'out-of-sequence' and have conditional accreditation with requirements to be met, a re-inspection is required as part of monitoring requirements or a change in accreditation status. All accreditation documentation and data is recorded in the Training Accreditation System (TAS), further details are provided in the 'Accreditation Data Management' section.

New Site Accreditation

New applications for accreditation can be submitted at any time to ANZCA. Every new training site seeking accreditation must first have approval and support from the relevant regional or national committee to join a rotational program. If approval or support is not provided, the accreditation application will not proceed.

Once ANZCA receives the application and all associated documentation, a review of the application is conducted by the TAC Chair or Deputy Chair to make an assessment of compliance against the accreditation standards and criteria. An onsite accreditation inspection is scheduled with the training site at a mutually convenient time. The accreditation team will review all documentation prior to the visit, and at the visit meet with senior staff, trainees, departmental leadership and senior health service management. The visit also includes an inspection of facilities. The length of time this process takes depends on availability of accreditation teams and the health setting seeking accreditation and could take several months to finalise.



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Re-Accreditation

In the case of re-accreditation, ANZCA will write to accredited training sites to advise of the re-accreditation requirement, negotiate a date for a site inspection and provide guidance on required documentation to be submitted to the TAC via the TAS. Documentation is locked down for review by the TAC Chair or Deputy Chair to make a preliminary assessment of continued compliance against the accreditation standards and criteria. The accreditation team then also have access to pre-visit documentation uploaded to the TAS.

In addition, trainees at the training site are requested to complete a 'trainee experience survey' as part of the pre-visit requirements. This confidential survey assists the accreditation team to gain an understanding of the training environment at the site and identifies any issues to be explored by the accreditation team during the inspection. This includes any roadblocks to meeting training requirements and trends in feedback and data that may mean trainees are not experiencing optimal training at a training site.

As for a new training site accreditation inspection, the accreditation team meet with senior staff, trainees, departmental leadership and senior health service management and include an inspection of facilities. The length of time this process is usually six months but can depend on training site availability.

Accreditation Teams

Accreditation teams consist of two to four trained FANZCA and one ANZCA staff member. The composition of teams takes into consideration conflict of interest, seniority of fellows, area of interest, trainee representation, regional committee membership and TAC membership to ensure balanced views with appropriate expertise and contextual knowledge.

Training is an important component of ANZCA accreditation to ensure consistency, balance and transparency in assessment against the standards. An accreditation training workshop is held at the Annual Scientific Meeting for fellows interested in participating in accreditation teams or as a refresher course. In addition, ANZCA has developed online training in the form of webinars and podcasts for accreditation visitors to access at any time.

Jurisdictional representatives do not currently participate on ANZCA accreditation teams.

Accreditation Outcomes

Accreditation outcomes are communicated in writing to the Chief Executive or head of a training site, the Director of Medical Services/Chief Medical Officer and Head of Department.

Unconditional Accreditation

All accreditation standards and criteria have been met and the hospital department and / or other training site are accredited for a full five year period. Sites may employ trainees from the beginning of the next employment cycle or year.

Conditional Accreditation

Full accreditation subject to conditions that need to be met. This includes corrective actions to become compliant within a specified timeframe. Sites may be subject to a further inspection as part of monitoring by the TAC.

Accreditation Not Approved

A new or change in status of accreditation application is not approved as accreditation standards and criteria have not been met. The site will be provided with written feedback from the TAC and ANZCA staff and regional committee members provide support to sites on actions required to become compliant. The site may be required to submit a new application at a later date.

Withdrawal of Accreditation

Accreditation may be withdrawn if a training site is unable to comply with accreditation standards and criteria. This can range from trainee wellbeing and safety to case mix, case load, supervision, facilities, etc. Issues with accreditation can be raised through Regional Committees, by contacting ANZCA, through the training committee, supervisor of training or education officer network.

In such cases, there is a significant impact on specialist training and professional standards and the decision to withdraw accreditation is made by ANZCA Council, under recommendation from the TAC. The TAC undertakes a thorough investigation of issues to verify claims and determine the course of action before any such recommendations are made to ANZCA Council.

As accreditation withdrawal can have a significant impact, particularly on trainees and workforce, ANZCA ensures that trainees are not adversely impacted by a decision in terms of their employment and will maintain 'accredited' training at a site until the end of rotation or training year, where possible. Trainees are also provided targeted supported to ensure their wellbeing. If there is a serious concern about trainee welfare, and the issue is substantiated, then ANZCA moves to promptly withdraw accreditation and redeploy trainees elsewhere within the rotational program, where possible.

ANZCA provides clear advice to the training site on the accreditation non-compliances with measures and timeframes for improvement. Support is provided to the training site to remediate issues and work towards regaining accreditation.

Accreditation Review

The TAC regularly reviews its accreditation framework, usually every three years. As part of the quality cycle, the TAC establishes project groups to research best practice models nationally and internationally to advance the ANZCA accreditation framework. The current iteration of the accreditation standards was implemented in 2016 with an update again in 2018.

Changes that have evolved over time and been implemented are more standardised criteria for assessment, a stronger focus on training experience, trainee wellbeing and safety, supervisor support, interviews at accreditation inspections with trainees and the development of the online accreditation database that is able to be accessed and used by accreditation teams while on accreditation visits with supporting data.

Triggers for change in the accreditation framework can come from a variety of things including issues raised by trainees and / or supervisors of training, a curriculum change, regulatory change from the AMC. ANZCA updated the curriculum in 2013/14 which instigated an update of the significant accreditation framework at the time.

ANZCA and the FPM completed an ANZCA and FPM Accreditation and Learning Environment Project (ALEP) in July 2021 to benchmark the College against international best practice in accreditation and set a strategic direction for the evolution of accreditation. The 15 ALEP recommendations include cross-program



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accreditation redesign with generic and specialty-specific standards and scalable processes, better monitoring of accredited sites, improved accreditor support, mapping of standards to graduate outcomes, improved data capture, data sharing with units, strengthened trainee input, and more robust accreditation of anaesthesia rotations. Implementation will be considered from 2022.³⁵

Accreditation Data Management

ANZCA has a data system that has been developed and implemented for the capture of accreditation data by all users called the ANZCA Training Site Accreditation system. This database holds information from past accreditation inspections and recommendations and any documentation uploaded to support accreditation outcomes including organisational policies and data sets.

Users include hospitals and health services, members of the TAC and College staff. Hospitals and health services can access, upload and input data required for accreditation as well as completed a self-evaluation assessment of performance against accreditation standards and criteria. The database assists health services to understand their own performance and identify any areas that may require further review or follow up by the accreditation team prior to an accreditation site visit.

The committee members who participate in site visits can access data submitted by the hospital and health services for pre-visit review.

Trainees complete an online training portfolio in the Trainee Portfolio System (TPS) to record training experiences to demonstrate that they have completed the minimum volume of practice for all the components of training. The information in the TPS reflects that trainees are completing training requirements, however, it does not reflect true case load and case mix. It has been identified by ANZCA that trainees enter the time that they've spent in training to meet requirements, once they have met requirements, other additional work is no longer recorded and they might not enter all the individual cases, as is done with logbooks.

The absence of comprehensive information of case load and case mix for trainees doesn't completely represent the type of clinical experience that the trainees are getting. This can be an issue from an accreditation perspective to be able to accurately identify case load and case mix at each accredited site and to ensure trainee safety. Case mix and case load are always explored by accreditation teams during accreditation inspections at training sites through documentation provided by the training site and interviews with trainees and supervisors.

Accreditation Evaluation and Quality Improvement

Audit, evaluation and quality improvement measures have been integrated into the accreditation process and ANZCA takes feedback from sites after visits via an online survey to assess the quality of the process and inspection. The survey includes whether the site received enough information, assistance and support in preparing for the accreditation inspection, communication, etc. There is also an accreditation 'Visitor Survey' that accreditation team members complete to provide feedback to ANZCA on process and possible improvements.

The results of these surveys are presented to every TAC meeting as part of continuous quality improvement.

35 https://www.anzca.edu.au/resources/education-unit/alepg_final-report_final_publish_20211210.pdf

Appendix C1: ANZCA Standards and Criteria for Accreditation

The list below outlines the standards and criteria for accreditation. Further details on minimum requirements under each criteria can be found in *the ANZCA Handbook for Accreditation December 2021 2.2*.³⁶

ANZCA Standards and Criteria for Accreditation

Accreditation criteria	Minimum requirements	How this is assessed
Standard 1 – Quality patient care		
Pre-anaesthetic consultation and consent. It is important that trainees are included in specialist-led pre-anaesthetic assessment clinic sessions.	Compliance with PG07(A) Guideline on preanaesthesia consultation and patient preparation and PS26(A) Position statement on informed consent for anaesthesia or sedation . There should be one specialist-led pre-anaesthetic assessment clinic (PAC) per week for every year of accredited normal time at the department (for example, for a department accredited for 104 weeks of normal training, there should be 104 specialist-led PAC sessions per annum).	Self-assessment. Audit data (preadmission rates, cancellation rates, etc).
Adequate facilities and systems for the administration of anaesthesia, major regional anaesthesia, sedation and monitored anaesthesia care, including the management of complications (including MH and anaphylaxis).	Compliance with PG03(A) Guideline for the management of major regional analgesia , PG18(A) Guideline on monitoring during anaesthesia , PS19(A) Position statement on monitored care by an anaesthetist , PG31(A) Guideline on checking anaesthesia delivery systems , PS54(A) Statement on the minimum safety requirements for anaesthetic machines and workstations for clinical practice , PS55(A) Position statement on minimum facilities for safe administration of anaesthesia in operating suites and other anaesthetising locations .	Self-assessment. Facilities inspection. Interviews with head of department, senior staff, theatre manager.
Adequate equipment to manage the difficult airway.	Compliance with PG56(A) Guideline on equipment to manage difficult airways .	Self-assessment. Facilities inspection.

³⁶ <https://www.anzca.edu.au/resources/all-handbooks-and-curriculums/anzca-handbook-for-accreditation>



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Accreditation criteria	Minimum requirements	How this is assessed
Adequate assistance for the anaesthetist.	Substantial compliance with PS08(A) Position statement on the assistant for the anaesthetist.	Self-assessment. Facilities inspection. Interviews with head of department, senior staff, theatre manager.
Compliance with guidelines on sedation.	Compliance with PG09(A) Guideline on sedation and/or analgesia for diagnostic and interventional medical, dental or surgical procedures. In terms of accreditation, this is only assessed in terms of those sedation cases undertaken by the anaesthesia department, although ANZCA recognises that this is the recognised standard for safety in sedation (for example, by the Medical Board of Australia).	Self-assessment. Facilities inspection. Interviews with head of department, senior staff.
Systems in place to ensure the safe administration of injectable drugs.	Compliance with PG51(A) Guideline for the safe management and use of medications in anaesthesia.	Self-assessment. Facilities inspection.
Adequate infection control procedures.	Compliance with PG28(A) Guideline on infection control in anaesthesia.	Self-assessment.
Adequate recording of episodes of care.	Compliance with PG06(A) Guideline on the anaesthesia record.	Self-assessment. Facilities inspection.
Adequate facilities for recovery from anaesthesia.	Compliance with PS04(A) Position statement on the post-anaesthesia care unit.	Self-assessment. Facilities inspection. Interviews with head of department, theatre manager, post-anaesthesia care unit staff.
Adequate systems for handover of care.	Compliance with PS53(A) Position statement on the handover responsibilities of the anaesthetist.	Self-assessment.
Provision of adequate perioperative pain management.	Compliance with PG41(PM) Guideline on acute pain management , PS45(PM) Position statement on the patients' rights to pain management and associated responsibilities. There should be one specialist-led acute pain service (APS) round per week for every year of accredited normal time at the department (for example, for a department accredited for 52 weeks of normal training, there should be 52 specialist-led APS sessions per annum). It is important that trainees are included in specialist-led acute pain service sessions.	Self-assessment. Facilities inspection. Interviews with head of department, senior staff, post-anaesthesia care unit staff, acute pain service nurse, trainees. Trainee feedback.
Provision of adequate care in the transport of critically ill patients.	Compliance with PS52(G) Guideline for transport of critically ill patients.	Self-assessment. Facilities inspection.

Accreditation criteria	Minimum requirements	How this is assessed
Systems and facilities to deal with patients selected for day care surgery.	Compliance with PG15(POM) Guideline for the perioperative care of patients selected for day stay procedures.	Self-assessment. Facilities inspection.
Where relevant to the training site:		
In cases where the hospital does not have a dedicated paediatric facility, adequate systems and facilities to deal with paediatric patients.	Compliance, where relevant, with PG29(A) Guideline for the provision of anaesthesia care to children.	Self-assessment. Facilities inspection.
Where Fellows practice extracorporeal perfusion.	Compliance with PG27(A) Guideline for major extracorporeal perfusion.	Self-assessment.
Where Fellows practice transesophageal and transthoracic echocardiography.	Compliance with PG46(POM) Guidelines on training and practice of perioperative cardiac ultrasound in adults.	Self-assessment.
Standard 2 – Clinical experience		
Clinical caseload and range adequate for training.	Caseload and complexity suitable for defined stages of training offered (see anaesthesia training program curriculum).	Self-assessment. Trainee portfolios. Trainee opinions. Interviews with supervisor of training, trainees.
Specialised study unit experience.	Caseload and complexity suitable for specialised study units offered.	Self-assessment. Trainee portfolios. Trainee opinions. Interviews with supervisor of training, trainees.
Standard 3 – Supervision		
Have sufficient full-time equivalent anaesthesia specialists to provide supervision for all trainees.	Adequate supervision levels. Specialist involvement in post-anaesthesia care. Specialist involvement in acute pain service.	Trainee experience surveys. Feedback from trainees. Trainee portfolios. Interviews with trainees, supervisor of training, senior staff and head of department.
Supervision levels appropriate.	Consistency in supervision between elective and acute / emergency clinical work around the clock, seven days a week. Patterns of supervision that allow trainee progression towards independent practice.	Trainee experience surveys. Feedback from trainees. Trainee portfolios. Interviews with trainees, supervisor of training, senior staff and head of department.



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Accreditation criteria	Minimum requirements	How this is assessed
Standard 4 – Supervisory roles and assessment		
Sufficient senior staffing.	<p>A suitably qualified director / head of department.</p> <p>A minimum of one specialist who holds FANZCA.</p> <p>A minimum of two full-time equivalent specialist anaesthesia staff with qualifications acceptable to ANZCA Council.</p> <p>Rostering that minimises the impact of fatigue for both senior staff and trainees (PG43(A) Guideline on fatigue risk management in anaesthesia practice).</p> <p>Staffing adequate for workload (PS42(A) Position statement on staffing of accredited departments of anaesthesia).</p>	<p>Self-assessment (datasheet),</p> <p>Staffing list provided by department.</p> <p>Senior and trainee rosters provided by department.</p> <p>Trainee experience survey.</p> <p>Senior staff interview.</p> <p>Head of department / director interview.</p>
Appointment of one or more supervisors of training, noting that a supervisor of training cannot be the head of department / director.	<p>Sufficient clinical support session per week for number of trainees.</p> <p>Access to private space for trainee interviews.</p> <p>Internet access.</p> <p>Locked filing cabinet for trainee records.</p> <p>See regulation 37.6.2.</p>	<p>iMIS records.</p> <p>Facility inspection.</p> <p>Feedback from supervisor(s) of training.</p> <p>Feedback from trainees.</p> <p>Completion of in-training assessment process and relevant reviews (training portfolio system).</p>
Appointment of clinical fundamentals tutor, introductory training tutor, specialised study unit supervisors, departmental scholar role tutors and provisional fellow supervisors where appropriate.	<p>Relevant supervisors and tutors appointed for each facet of clinical experience offered.</p> <p>See regulation 37.6.3.</p>	<p>Head of department / director interview.</p> <p>Supervisor of training interview.</p> <p>Feedback from trainees.</p>
Performance of workplace-based assessments including feedback.	<p>Minimum mandatory workplace-based assessments (see anaesthesia training program curriculum) performed including feedback.</p>	<p>Feedback from trainees.</p> <p>Supervisor of training interview.</p> <p>Trainee portfolio system.</p>
Specialists have contemporary standards of practice.	<p>As per PG50(A) Guideline on Return to anaesthesia practice for anaesthetists, PS57(A) Position statement on duties of specialist anaesthetists and PS40(G) Position statement on the relationship between fellows, trainees and the healthcare industry.</p>	<p>Self-assessment.</p> <p>Interviews with head of department, senior staff, trainees.</p> <p>Continuing professional development compliance.</p>

Accreditation criteria	Minimum requirements	How this is assessed
Standard 5 – Education		
Teaching program.	Formal teaching program that meets the needs of trainees (relevant to size of department). Adequate opportunities must exist for completion of scholar role activities in basic and advanced training.	Copy of education program. Feedback from trainees.
Learning experiences planned.	Planning clinical placement review interviews.	Feedback from trainees. Supervisor of training interviews.
Informal teaching.	Trainees receive informal teaching during clinical work, including pre-anaesthetic assessment clinics and acute pain service rounds.	Interviews with senior staff, trainees. Feedback from trainees.
Standard 6 – Facilities		
Access to private study space for trainees.	Internet access. Desks at which to study. Easily accessible from theatre complex.	Facilities inspection. Feedback from trainees.
Adequate library facilities with information sources appropriate to anaesthesia and its sub-specialties.	Appropriate to size of department and specialised study units offered.	Facilities inspection. Feedback from trainees.
Adequate secretarial staff.	Usually at least one full-time equivalent. Larger departments will require several. See section 18.3 of the ANZCA handbook for training.	Self-assessment. Size of department.
Adequate office space for specialist staff.	Specialists able to access space for performance of clinical support duties.	Interviews with head of department, senior staff. Facilities inspection.
Access to a suitable conference room for quality assurance, clinical review and educational activities.		Interview with head of department. Facilities inspection.
Ready access to appropriate computer facilities for specialists and trainees, including infrastructure for on-line completion of training portfolio system (including workplace-based assessments).	See section 10 on the Training Portfolio System .	Interviews with head of department, supervisor of training, tutors and trainees. Facilities inspection.



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Accreditation criteria	Minimum requirements	How this is assessed
Standard 7 – Clinical governance		
Senior staff appointed in a transparent way.	Appointment of staff according to PS02 Statement on Credentialing and Defining the Scope of Clinical Practice in Anaesthesia with a properly convened committee, with job descriptions in accordance with PS57(A) , Position statement on duties of specialist anaesthetists and positions advertised with information that the department is ANZCA accredited.	Self-assessment. Interview with head of department.
Trainees appointed using a transparent process as outlined in this handbook.	Trainee Selection (see the section 3 of the ANZCA handbook for training)	Interviews with head of department, supervisor of training. Confirmation with regional / national committee representative.
Ensure that trainees are adequately indemnified by the employer for their supervised practice on both public and private patients.		Interviews with head of department, senior hospital management.
The hospital has a policy on bullying and harassment that pertains to trainees and their supervisors.		Interviews with head of department, senior hospital management.
Staff administering anaesthesia are suitably qualified.	Credentialing and scope of practice defined for staff as per PS02(A) Position statement on credentialing and defining the scope of clinical practice in anaesthesia .	Self-assessment. Interviews with head of department, senior hospital management.
The organisation supports the health and wellbeing of its staff.	As per PS49(G) Guideline on the health of specialists, specialist international medical graduates and trainees . The organisation has a policy to prevent bullying and harassment.	Self-assessment. Interviews with head of department, senior hospital management.
The organisation is accredited.	ACHS or HealthCERT (NZ).	Interviews with head of department, senior hospital management.
The department has a quality assurance program.	As per PS58(A) Guideline on quality assurance and quality improvement in anaesthesia . Quality assurance coordinator appointed. Trainees involved in quality assurance activities.	Self-assessment. Interviews with head of department, senior staff, trainees. Feedback from trainees.

Appendix D: College of Intensive Care Medicine (CICM)

The College of Intensive Care Medicine of Australia and New Zealand (the College/CICM) was established in 2008, and on 1 January 2010, assumed the responsibility for intensive care medicine specialist training and education in Australia and New Zealand. CICM offers a minimum six year training program, in both general and paediatric intensive care, with a number of assessments, culminating in Fellowship of the College of Intensive Care Medicine (FCICM).

CICM advocates for health and social policies to improve the healthcare of all Australians and New Zealanders. CICM also ensures patients are treated by well-trained, qualified intensive care specialists, in both general and paediatric intensive care medicine, who continue to improve their skills, qualifications and clinical practice through continuing education.³⁷

CICM has approximately 1,331 Fellows throughout the world. In April 2021, CICM represented 1,044 Fellows and 686 advanced intensive care trainees in Australia.

The CICM Strategic Plan is for the period 2021–2023. The plan covering three years was developed to direct the activities of CICM in the commitment to ‘support our members to be leaders in intensive care medicinetraining and professional standards’.³⁸

CICM has developed the four pillars that will shape our priorities and form the strategic direction over the next three years. These are:

- **Pillar 1:** Best Practice in Education, Training and Assessment;
- **Pillar 2:** Highest Professional Standards;
- **Pillar 3:** Advancing equitable access to intensive care;
- **Pillar 4:** Maturing our internal College capabilities.

Pillar 1 sets out our key initiatives that evolve our education and training programs, our approach to modernising assessment, and the support for our educators and Supervisors of Training to achieve it.

Pillar 2 builds on our solid foundation of member engagement. It also promotes cultural safety and diversity throughout the specialty by supporting a diverse workforce.

Pillar 3 involves engaging with rural and regional areas to ensure equitable access to critical care through workforce levers, building productive reciprocal relationships in the critical care community to achieve better outcomes for all patients and raising the profile of intensive care across Australia and Aotearoa New Zealand to increase our relevance and grow our influence.

³⁷ <https://www.cicm.org.au/About/About-Us>

³⁸ College of Intensive Care Medicine, Strategic Plan 2021–2023, https://www.cicm.org.au/CICM_Media/CICMSite/Files/Corporate/Strategic-Plan-2021-2023.pdf



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Pillar 4 supports CICM to continuously evolve and improve in line with the strategic directions. This involves evolving and maturing our internal functions to ensure CICM has robust and future-ready governance, systems, workforce and technology.

CICM is accredited by the AMC until 31 March 2022 and will undergo a full reaccreditation assessment of the education and training and professional development programs by the AMC and New Zealand Medical Council during 2021 and 2022.

College Governance

The CICM Board appoints Chairs to committees annually following the Annual General Meeting. Chairs of committees will normally be members of the Board. The President is an ex-officio member of all CICM Committees.³⁹ The Committees' Terms of References are monitored and reviewed regularly.

The following Principal Committees report directly to the Board:⁴⁰

- Assessments Committee
- Censor's Committee
- Community Advisory Group
- Education Committee
- Executive Committee
- Finance, Audit and Risk Management Committee
- Fellowship Admissions Committee
- Fellowship Affairs Committee
- Hospital Accreditation Committee
- Indigenous Health Committee
- Overseas Aid Committee
- Paediatric Committee
- Rural Committee
- Specialist Training Program Advisory Committee
- Trainee Committee.

³⁹ CICM Regulations, Clause 2.4,
https://www.cicm.org.au/CICM_Media/CICMSite/Files/Regulations%20and%20Constitution/C_Gen_Regulations.pdf

⁴⁰ <https://www.cicm.org.au/About/Sub-Committees>

Accreditation Governance

The Hospital Accreditation Committee (HAC) reports directly to the CICM Board. It is a committee of the board with delegated authority, the Chair of the HAC is a member of the Board. All HAC committee members are appointed by the Board including the Deputy Chair, the President, the Education Officer and the Censor who all have key CICM portfolios.

The HAC implements Board policy, provides advice on accreditation and makes recommendations on accreditation of training site outcomes to the Board. The committee is responsible for accreditation and review of training sites and documentation, accreditation inspections, appointment of inspections teams and data collation and analysis of accredited and prospective sites. The HAC meets three to four times per annum.

Approximately 20 training sites are accredited each year.

Specialty Training Program

The General Intensive Care Medicine Training Program⁴¹ is a minimum of six years with training requirements varying depending on any prior experience or skills recognised by CICM. The program is broken down into 42 months across the following stages:

- Foundation Training (six months) – a prerequisite requirement prior to selection into the specialty training program which provides for a foundational experience. CICM First Part Examination follows this training and successful completion is a pre-requisite for entry to core training.
- Core Training (24 months) – at least 12 months must be continuous at one location. Subspecialty units include cardiothoracic surgery intensive care, neurological/ neurosurgery, trauma intensive care.
- Transition Year (12 months) – Successful completion of the CICM Second Part Examination and all associated training requirements is a pre-requisite for commencement in the Transition Year and final year of training. Trainees must complete this year in an approved 'Transition Year' position in an ICU.

There is also a requirement for subspecialty or training exposure in the following areas for corresponding length of time:

- Clinical Anaesthesia (12 months) – Anaesthesia and peri-operative management that are relevant to the practice of an intensivist
- Clinical Medicine (12 months) – Six months must be in acute care and six months in longitudinal medicine
- Paediatric – CICM, ACEM, ANZCA, RACP or RACS (six months)
- Elective (six months)
- Rural training in any discipline (three months).⁴²

The Paediatric Intensive Care Medicine Training Program⁴³ is a minimum of six years and 42 months as per the General program. The variation is that 18 months of core training must be in a paediatric intensive care unit and the medicine component of training must be completed in paediatric medicine.

41 <https://www.cicm.org.au/Trainees/Program/General>

42 CICM Guidelines for the Rural Term, T34, March 2022,
https://www.cicm.org.au/CICM_Media/CICMSite/Files/Training/T-34-Guidelines-for-the-Rural-Term.pdf

43 <https://www.cicm.org.au/Trainees/Program/Paediatric>



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Entry numbers to the intensive care medicine training program vary each year. 2020 was the first single intake year with 204 new trainees. This is an increase from previous years where there were approximately 140 to 150 new trainees per annum. Over the course of the program, CICM experiences a high attrition rate, some are dual trainees and choose to drop off a specialty, some run out of time and do not complete requirements. In 2020, CICM had 62 new Fellows, with approximately 70 new Fellows each year. When trainees engage in dual training they commonly choose Emergency Medicine, Anaesthesia or Physician – Respiratory Medicine training. If a trainee is a Fellow of one of those colleges or has completed certain training components of one specialty training program, it may provide exemptions in the intensive care medicine training program. Dual Fellowships has become popular and provides for enhanced career options, particularly in rural locations.⁴⁴

Supervision

Supervisors of training must be approved by CICM via a nomination made by a Director of Training. They must have broad knowledge of CICM activities, policies and the training context for intensive care medicine training. Supervisors must be FCICM except in the case of non-intensive care rotations and training exposure. Non-intensive care supervisors must still be approved by CICM. Clinical supervisors may be non-Fellows of CICM and required to sign off on some trainee assessments.

Supervisors oversee clinical performance, provide formative feedback on performance, complete summative work-based assessments with trainees and monitor trainee progression.

FCICM supervisors should be at least three years post-Fellowship, be appointed by the health service at no less than 0.5 FTE and, once approved by CICM, only supervise up to 10 trainees at a time.

Rotations

CICM does not have formalised rotations. This may be driven on a jurisdictional basis, for example, in Queensland a rotational system exists, however, CICM encourages trainees to engage in self-directed learning and seek their own training experiences in line with their training plan and specialty training program requirements. Trainees need to seek approval of each accredited training term and will have this signed off by CICM both in advance of the term and at the conclusion of the term.

Apart from Core training that has a minimum of 6 months, rotational terms are a minimum of three months. While not common, some arrangements exist for trainees in a 12 month rotation to do a three month rural rotation within that term.

44 CICM Interview with Department of Health (DOH) transcript, December 2019

Accreditation Framework

Intensive care medicine training can only occur at a health setting with an ICU and intensive care specialists. Not all ICUs in Australia are accredited for training, particularly in the case of smaller ICUs.

CICM accredits ICUs with the number of trainees in training at each site to be determined by the training site. Accredited sites must provide formal education, teaching and research programs at accredited sites including tutorials, case reviews, case presentations and mortality and morbidity reviews. In addition, trainees must be able to take part in quality audit and assurance activities.

CICM designates sites as:

- Foundation
- Limited General Training
- General Training
- Cardiac Surgical (Cardio)
- Neurosurgical (Neuro)
- Trauma
- Adult Paediatric (AP6 or AP12 depending on length of rotation at site and for General Training sites)
- Rural.^{45, 46}

CICM accreditation standards apply for Foundation Training, Core Training and Transition Training. There are separate minimum accreditation criteria for Foundation Training that applies to hospitals who are not accredited and wish to deliver Foundation Training. However, any hospital that is accredited for General Intensive Care Medicine Training, will be suitable and can deliver Foundation Training and Elective Training.

Currently, the number of accredited training sites outweighs the number of trainees in the training pipeline meaning that trainees usually have no difficulty finding accredited training positions to complete the requirements of the training program and training bottlenecks do not exist.

Foundation Training Accreditation Criteria

To be accredited for Foundation Training, an ICU must be established and operational and meet set criteria outlined under the 'Minimum standards for Intensive Care Units Seeking Accreditation'⁴⁷ and Minimum Criteria for Hospitals Seeking Accreditation for Foundation Training in Intensive Care Medicine.⁴⁸ The relevant College Regional/National Committee must endorse Foundation Training accreditation applications received by the College. This endorsement is taken into consideration when the HAC is assessing the overall application.

45 <https://www.cicm.org.au/Hospitals/Accredited-Sites-Accordion/Accredited-Units>

46 <https://www.cicm.org.au/Hospitals/Accredited-Sites-Accordion/Paediatric-Accredited-Units>

47 Minimum Standards for Intensive Care Units Seeking Accreditation for Training in Intensive Care Medicine, IC-3, November 2021, https://www.cicm.org.au/CICM_Media/CICMSite/Files/Professional/IC-3-Minimum-Standards-for-Intensive-Care-Units-Seeking-Accreditation.pdf

48 Minimum Criteria for Hospitals Seeking Accreditation for Foundation Training in Intensive Care, IC-33, 2020, https://www.cicm.org.au/CICM_Media/CICMSite/Files/Professional/IC-33-Minimum-Criteria-for-Hospitals-Seeking-Accreditation-for-Foundation-Training-in-Intensive-Care-Medicine.pdf



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Accreditation Standards and Criteria

All sites accredited for training must meet the minimum standards relating to work practice, caseload, staffing and operational requirements, design, equipment and monitoring for Level III, Level II, Level I and Paediatric ICUs. The standards define the resources required to provide safe patient care and best outcomes for each level of ICU.⁴⁹

Under the General Training Program and Paediatric Intensive Care Program, there are different accreditation designations for ICUs. These designations are determined according to case load, case mix, severity of illness of patients, range and frequency of procedures, supervision of trainees and facilities of the ICU.

The following sections shows the classifications of a unit accredited for training and the relevant criteria required to be met:

General Training (Gen)

Level III major intensive care units and paediatric units, tertiary referral or large district hospital where trainees can undertake an unrestricted amount of core intensive care training, up to 24 months. The unit has:

- More than three FCICMs with at least two with 0.5 FTE time in the ICU.
- Established teaching, research and quality assurance programs.
- Appropriate case load and case mix with a high degree of severity and complexity. Exposure to burns, transplant services and spinal injuries is desirable.
- Case numbers that exceed 750 per annum with at least a 40% ventilation rate.

Limited General Training (G6)

Level II and Level III intensive care units and paediatric units that have a case load, case mix, supervision and facilities that allow for a maximum of six months training. The unit has less complex and severe cases with a lower number of cases

Neurosurgical Intensive Care Training (Neuro)

The site has a designated neurosurgical department that manages complex neurosurgical and neurotrauma patients with a sufficient ICU case load and case mix. Units may be so designated if the patients are managed within a dedicated geographical site or intermingled amongst a more general ICU population. Trainees must have direct involvement in patient care under the supervision of an intensive care specialist.

Cardiac Surgical Intensive Care Training (Cardio)

The site has a designated cardiothoracic surgery department managing complex cardiac surgery, appropriate case mix and a minimum of 250 cases per annum. Units may be so designated if the patients are managed within a dedicated geographical site or intermingled amongst a more general ICU population. Trainees must have direct involvement in patient care under the supervision of an intensive care specialist.

49 Minimum standards for Intensive Care Units, 2016, https://cicm.org.au/CICM_Media/CICMSite/CICM-Website/Resources/Professional%20Documents/IC-1-Minimum-Standards-for-Intensive-Care-Units_2.pdf

Trauma Intensive Care (Trauma)

The site has a designated trauma unit or department with appropriate case mix and case load of complex trauma. Units may be so designated if the patients are managed within a dedicated geographical site or intermingled amongst a more general ICU population. Trainees must have direct involvement in patient care under the supervision of an intensive care specialist.

Paediatric Intensive Care (AP6 or AP12) for General Intensive Care Training

The site or unit meets the requirements for either Limited General Training or paediatric training. Adult or mixed intensive care units will be designated as paediatric training sites for this purpose if the intensive care unit admits and manages a sufficient paediatric case load and case mix. Trainees must have direct involvement in the care of these patients under the supervision of an Intensive Care Specialist. Units admitting and managing more than 100 paediatric patients annually will be designated Paediatric 6 month sites (AP6), while those admitting and managing between 50 and 100 patients will be designated Paediatric 12 month sites (AP12).

Accreditation Process

CICM's accreditation cycle is 5-yearly, in which currently accredited units undergo the reaccreditation process. Additionally, units lodging new applications, seeking upgrades and requiring follow ups will also undertake the accreditation process on a case-by-case basis.

New ICUs must be operational for a period of time before CICM will consider an accreditation application.

CICM utilises the Hospital Accreditation System (HAS) as a repository for accreditation related data. ICUs seeking new accreditation or reaccreditation for General Training or Limited General Training, must complete an online hospital datasheet via the HAS, as well as provide staff and education rosters, and the ICU Director's curriculum vitae (new ICUs only). The datasheet has 232 questions relating to supervisors, examiners, staff, rostering, case mix, case load, case numbers, ICU admissions, infrastructure etc. The datasheet and associated documents are assessed by the HAC and a site visit of the ICU is conducted to validate the data prior to an accreditation outcome being made.

Currently, Foundation Training reaccreditation and new accreditation applications are paper based. Applications are reviewed and endorsed by the relevant CICM Regional/ National Committee, before progressing to the HAC to issue an accreditation outcome. A physical site inspection of a Foundation Training ICU is generally not required, and the application is assessed on the data and CICM Regional/ National Committees' feedback.



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Accreditation Teams

The composition of accreditation teams is a significant component of ensuring that accreditation assessments are balanced, consider, consistent and objective. To reduce potential for conflict of interest to occur, Accreditation Team members must not currently work in the ICU that is being inspected.

Accreditation Teams consist of the following members:

- Lead Inspector – a FCICM who is a current or previous CICM Board member and a FCICM who does not reside in the same state/ jurisdiction as the ICU.
- Two FCICMs – residing in the same state/jurisdiction as the ICU who are selected by the relevant Regional/National Committee.
- Trainee Representative – residing in the same jurisdiction who is selected by the relevant Regional/ National Committee.
- Observer – optional, and may be FCICM, trainee or CICM staff member.

Accreditation training has not yet been formalised by CICM, however, the HAC ensure that experienced Accreditation Team members provide guidance and support to new Accreditation Team members. CICM plans to develop an online training course for Accreditation Team members including an induction pack, with inspection script and guidelines.

Site Inspections

Site inspections provide the Accreditation Team with the opportunity to validate data that the ICU outlined in the datasheet, ensure the physical facilities and equipment comply with CICM's minimum standards, and interview relevant staff including the ICU Director, ICU Supervisor/s of Training, ICU staff specialists, CICM trainees, ICU nursing staff, and members of the hospital executive.

In preparation for the inspection, CICM provides the Accreditation Team with access to the HAS where they can review the hospital datasheet, historical correspondence and the results of the CICM Trainee Survey (for the site).

Accreditation Outcomes

At the conclusion of the site visit, the Accreditation Team provides preliminary feedback to the health service executive and Director of the ICU. After the site visit, the Lead Inspector prepares the accreditation report for the HAC providing recommendations on any areas that require attention, commendations for any areas the hospital is excelling and the accreditation outcome of the assessment. The outcome of the assessment will be either:

- Accredited – Retained
- Accredited – Conditional
- Accredited – Downgraded
- Not Accredited.

As part of the accreditation outcome the ICU may be required to fulfill remediation activities to ensure the site remains compliant with CICM's accreditation requirements. Any conditions have been set into short term requirements (immediate to 12 months), medium term requirements (within the next five years) and long term recommendations (5+ years). Long-term requirements could be recommendations on improvements to infrastructure and facilities.

The HAC and/or Board review the accreditation report and determine the accreditation outcome. The HAC issues the hospital a comprehensive letter outlining the accreditation outcome and recommendations of further actions that the hospital/ ICU must fulfill. CICM Regional/ National Committee also receives a copy of this correspondence. CICM applies a level of flexibility in relation to some aspects of the accreditation standards for rural training sites. An example is a site that is very close to meeting the requirement for the ventilation rate of patients but doesn't quite meet the mark, however, CICM has acknowledged the value of training site and approved that the site be accredited.

Accreditation Monitoring and Review

CICM reviews and monitors accreditation through the following initiatives:

CICM Trainee Survey

This is administered to trainees every six months and provides an opportunity for trainees to provide feedback on their training experience. There are approximately 40 questions where trainees are asked to rank their training experience in different categories including supervision, learning experiences, quality, culture, performance of the post and support.

Cumulative results are provided back to ICUs, with the number of responses determining whether the ICU receives a site specific or overview report. The survey is also used to inform the Accreditation Team of any concerns that require further discussion during the site inspection.

Australian and New Zealand Intensive Care Society (ANZICS) data sharing

ANZICS supplies the College with data from the CORE Adult Patient Database, which is used to inform the accreditation process. ANZICS is a membership organisation that advocates on intensive care matters, clinical research and clinical trials and provides professional education and analysis of critical care resources. Members of ANZICS include FCICM, non-CICM Fellows, medical practitioners, nurses, researchers, database managers, allied health practitioners and international Fellows.

CICM undertakes reviews of the accreditation framework as required. One of the main drivers of change in the accreditation framework is changes in the specialty training curriculum.⁵⁰

Apart from improvement of the IT infrastructure, the trainee feedback surveys and addition of a trainee representative on Accreditation Teams has been a key and vital change for CICM in improving accreditation practices. The framework is now more robust and transparency has been increased through the integration of the web-based platform and standardised templates.⁵¹

50 CICM Preliminary DoH Online Survey Response, October 2019

51 CICM Interview with Department of Health (DOH) transcript, December 2019



Accreditation Data Management

Since 2019, CICM has used a purpose-built, web-based platform for the collection of hospital data and accreditation information using the Content Management System, Kentico.⁵²

HAS provides greater transparency surrounding accreditation information and other historical data uploaded and retained in the system. Data from the HAS is exported to a series of Microsoft Power Bi reports to enable CICM to gain a bigger picture understanding of the intensive care medicine training experiences in Australia and overseas.

The HAS is the main communication point with ICU Directors for the College and is accessible by FCICM directors and supervisors at health services to upload accreditation information and ICU data information including supervisors, examiners, staff, rostering, case mix, case load, case numbers, ICU admissions, infrastructure, etc. The HAS is comprised of three distinct views and displays information according to the user type:

- Administration portal – accessed by CICM staff who facilitate the accreditation process and members of the HAC for the purpose of reviewing accreditation application data and accreditation reports to inform the accreditation outcome.
- Inspector Dashboard – access is provided to each member of the Accreditation Team where accreditation data pertaining to the ICU can be reviewed. Governance workflow has been built into the HAS so that accreditation reports can be completed online by the Lead Inspector, reviewed by other accreditation team members and CICM staff before being finalised and recommendations submitted to the HAC and CICM Board for endorsement or approval and/or noting.
- Director Dashboard – accessed by the ICU Director for the purposes of completing accreditation data and accessing correspondence that CICM holds on the ICU.
- HAC Dashboard – accessed by members of the HAC for the purpose of reviewing accreditation application data and accreditation reports to inform the accreditation outcome.

CICM aims to move to a completely paperless accreditation system with mobile capability on iPads or computers.

The system allows for notifications and reminders to both training sites and CICM, particularly in relation to accreditation conditions and timeframes for completion.

⁵² <https://www.kentico.com/>

Appendix D1: CICM Foundation Training Accreditation Criteria

The table below identifies the Minimum Criteria for Hospitals Seeking Accreditation for Foundation Training for Intensive Care. Full documentation can be found on the CICM website.⁵³

Table 3. CICM Minimum standards for Intensive Care Units Seeking Accreditation for Foundation Training

Foundation Intensive Care Medicine Training Criteria	
3.1	A minimum five (5) beds with simultaneous invasive ventilation capacity of at least three (3) beds;
3.2	A minimum case load of 250 ICU patient admissions annually with: <ul style="list-style-type: none"> • a broad case mix including both general medical and surgical patients; • reasonable patient illness acuity including some patients who receive invasive ventilation for more than 24 hours.
3.3	At least one (1) Intensive Care Specialist who is a Fellow of the College (FCICM) and who has a significant clinical role within the unit;
3.4	Established policies and procedures covering admission, discharge and common clinical situations;
3.5	Established policies and procedures for transport of patients into the ICU and out of the ICU to an appropriate, higher level facility;
3.6	Appropriate numbers of trained and experienced nursing staff;
3.7	The majority of nursing staff will have undertaken or be engaged in postgraduate training in Intensive Care;
3.8	Capability for and regular use of invasive haemodynamic monitoring;
3.9	Capability for and regular use of invasive and non-invasive mechanical ventilation;
3.10	ICU participation in emergency (for example, Medical Emergency Team or cardiac arrest) and outreach programs;
3.11	Availability of teaching and resource material including internet access, textbooks, journals;
3.12	Established review processes (for example, Quality Assurance, Mortality and morbidity, critical incident monitoring, clinical indicators);
3.13	Medical Director with an appropriate specialist qualification;
3.14	Nurse Manager with an appropriate, post-graduate qualification;
3.15	The trainee appointment must be substantially in Intensive Care. Some participation in the clinical activities of an associated unit is allowable, especially for 'out-of-hours' practice (for example, cross cover with anaesthesia);
3.16	An appropriately trained and experienced medical specialist must supervise the clinical practice of the trainee. Supervision must be available at all times. See T-10 The Role of Supervisors of Training in Intensive Care Medicine.
3.17	There must be a structured education program in which the trainee participates. If the program is hospital-based, there must be a significant Intensive Care component.

53 CICM Minimum Criteria for Hospitals Seeking Accreditation for Foundation Training for Intensive Care, https://www.cicm.org.au/CICM_Media/CICMSite/Files/Professional/IC-33-Minimum-Criteria-for-Hospitals-Seeking-Accreditation-for-Foundation-Training-in-Intensive-Care-Medicine.pdf



Appendix D2: Minimum Standards for Intensive Care Units Seeking Accreditation for Training in Intensive Care Medicine

The table below outlines the General Intensive Care Medicine accreditation criteria. Full details can be found on the CICM website.⁵⁴

Table 4. CICM Standards for General Intensive Care Medicine Training

1. General Accreditation Requirements

This section is for accredited ICUs. The requirements for affiliated ICUs are in section 2.5 of this document.

- | | |
|---|---|
| <p>1.1 Accreditation approval is granted for a five-year cycle. ICUs accredited for training by the College must meet the following criteria:</p> | <p>1.1.1 The ICU must fulfil the requirements outlined in IC-1 <i>Minimum Standards for Intensive Care Units</i> with Foundation Units being Level I or above and Limited General Units (C6) being Level II or above. General Training Units (C12 or C24) will usually be Level III Units with some Level II Units also able to provide General Training (C12 or C24) experience.</p> <p>1.1.2 The ICU must offer trainees a wide spectrum of experience with an acceptable case load.</p> <p>1.1.3 The hospital should provide a comprehensive range of medical and surgical specialties.</p> <p>1.1.4 The hospital must provide access to an appropriate spectrum of investigations and therapeutic procedures that are suitable for the case mix.</p> <p>1.1.5 The hospital must have an orientation program for all new doctors, including trainees, working in the ICU.</p> <p>1.1.6 The hospital must ensure that training appointments are based in intensive care and should include provision for the trainee to take part in out-of-hours rosters in intensive care. The management of critically ill patients outside the ICU has increasingly become part of ICU core business and the participation of trainees in Rapid Response, Medical Emergency, or Outreach roles is permitted as part of core ICU training. ICUs should ensure these "Out-of-ICU Roles" have adequate intensivist supervision available at all times and trainees continue to have appropriate exposure to critically ill patients. Rostering to night-time shifts should not exceed 50 per cent and ideally would be less than this. The percentage of time a trainee is rostered to out of ICU activities should not exceed 25 per cent. An increase to 33 per cent of rostered time is possible if strategies are implemented to ensure direct supervision by an ICU specialist and clinical exposure to critically ill patients.</p> <p>1.1.7 ICU policies and rosters must ensure trainees can work adequate hours within the ICU as distinct from HDUs or other rostered duties. This should involve adequate clinical experience including</p> |
|---|---|

54 CICM Minimum Standards for Intensive Care Units Seeking Accreditation for Training in Intensive Care Medicine, https://www.cicm.org.au/CICM_Media/CICMSite/Files/Professional/IC-3-Minimum-Standards-for-Intensive-Care-Units-Seeking-Accreditation.pdf

-
- performance of procedures. If the Censor deems that inadequate hours are worked in intensive care medicine, they may rule that the trainee(s) must extend the duration of their core training.
- 1.1.8 The ICU should have guidelines on effective communication and clinical handover procedures to ensure mutual understanding and retention of information. This should include handovers to or from referring hospitals and retrieval specialists.
- 1.1.9 Safe working hours for trainees must be maintained and welfare issues addressed. It is expected that trainees will work and learn in an environment that is supportive, respectful, and free from harassment, bullying and undue conflict.
- 1.1.10 When appointments to the specialist staff are made, the advice of a properly constituted committee must be sought. College nominees are available to committees for this purpose.
- 1.1.11 When appointments for training registrar positions are made, they must be advertised. The selection process must conform to College guidelines and involve a properly constituted committee that includes a Fellow of the College (FCICM).
- 1.1.12 All accredited ICUs must allow the College access to data submitted to the Australian and New Zealand Intensive Care Society's Centre for Outcome and Resource Evaluation (ANZICS CORE) or provide data annually from other relevant databases that allows calculation of the standardised mortality ratio (SMR) and benchmarking with other ICUs.
-
- 1.2 The ICU must offer, or provide access to, a program of education, quality assurance and research that includes a formal teaching program readily available to trainees. The program should cover general aspects of intensive care medicine in addition to directed education for trainees preparing for both the First Part and Second Part examinations.
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- 1.3 The ICU must offer on-site access to adequate intensive care educational resources including electronic and internet-based resources, textbooks, journals, management guidelines and protocols or clinical care pathways.
-
- 1.4 The hospital must be prepared for the College, at intervals determined by the Board, to carry out visits to the ICU to assess its suitability for training. Information about caseload, staffing patterns and the rosters must be provided.
-
- | | |
|--|---|
| 1.5 The hospital must agree to notify the Board of any changes that might affect training, including but not limited to: | 1.5.1 A change in the Supervisor of Training or Director. |
| | 1.5.2 A change in the workload. |
| | 1.5.3 A significant change in case-mix or acuity. |
| | 1.5.4 A reduction in the number of specialist staff working in the ICU. |
-
- 1.6 The ICU should demonstrate a commitment to diversity through areas such as employment policy, training programs, and cultural advisory inputs.
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- 1.7 The ICU should demonstrate a commitment to cultural safety in its delivery of care and stewardship.
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Appendix E: Royal Australasian College of Medical Administrators (RACMA)

The Royal Australasian College of Medical Administrators (RACMA) is a specialty medical college delivering medical management and leadership training to medical practitioners. RACMA is a membership organisation accredited to deliver the medical administration specialty training program leading to the award of specialist Medical Administrator.

As at June 2019, RACMA had 519 Fellows, 415 Associate Fellows, 17 Affiliate member and 189 trainees⁵⁵ (Candidates) in Australia, New Zealand and Hong Kong. All members must be medical practitioners to join RACMA.

A not-for-profit organisation, RACMA is committed to achieving excellence in the Speciality of Medical Administration in Australia, New Zealand and the Asia Pacific Region, in order to enhance and maintain high standards of health care across the region.

RACMA's objectives⁵⁶ are:

- To promote and advance the study of the principles and practice of health services management by medical practitioners.
- To establish and maintain the highest standards of learning, skill and conduct by medical practitioners engaged in health services management.
- To establish, conduct and promote educational programs in health services management.
- To promote mutual understanding between persons engaged in the field of health services management and to promote good relations between such persons engaged in the practice of medicine and between such persons and the community.
- To recognise by Honorary Fellowship or by special award, persons of distinction in the fields of medicine and health services management.

The RACMA *Strategic Plan 2021–2024*⁵⁷ informs business and operational planning for the College and focuses on four key areas:

- To be the recognized and respected voice of health leadership, management, and governance.
- To be the pre-eminent provider of medical leadership and management education and training.
- To deliver high-quality member services and support.
- To advance and expand our influence as a college.

55 RACMA Annual Report 2019, https://racma.edu.au/wp-content/uploads/2019/11/2019-Annual-Report_191121_FINAL.pdf

56 <https://racma.edu.au/about-us/governance/>

57 <https://racma.edu.au/about-us/governance/strategic-plan/>

College Governance

RACMA is governed by a board of eleven members including the President, Vice President, Chair of the Education and Training Committee, Chair of Finance and Audit Committee and three additional Fellows, an Associate Fellow, a Candidate Representative and two external representatives with special expertise.

The Education and Training Committee (ETC) and Finance and Audit Committee are standing committees of the board. An additional committee reporting to the board is the Policy and Advocacy Committee.

RACMA has eight Jurisdictional Committees reporting to the board including Australian Capital Territory, New South Wales, Victoria, Western Australia, South Australia, Tasmania, Queensland/Northern Territory and New Zealand. Part of the role of the jurisdictional committees is to provide support to trainees and participate in the accreditation functions of RACMA.

The ETC has sub-committees reporting to it being the Board of Censors, Continuing Education Program Committee, Candidate Advisory Committee, Training Progress Committee, Academic Board and the Accreditation Committee (AC). Meetings occur four times a year or out of session, as required.

RACMA also has a Rural Advisory Group (RAG) consisting of Fellows in rural areas from each jurisdiction across Australia and New Zealand. The RAG provides advice to the ETC on matters related to rural and regional medical administration practice and training.

Accreditation Governance

The AC membership consists of Jurisdictional Coordinators of Training (JCTs) and Fellows who are involved in the accreditation of training posts. The AC meets six times a year or papers are distributed out of session depending on number of accreditations to be reviewed. The members of the AC consider accreditation recommendations from accreditation panels and either endorses or makes a decision to alter the recommendations. The AC undertakes policy and regulation review in relation to accreditation and undertakes reviews of the accreditation standards and criteria in relation to regulatory, specialty training program, curriculum and assessment changes.

The AC makes recommendations on the accreditation of training posts to the ETC for approval. The ETC will approve or not approve recommendations and report back to the AC. The ETC reports all accreditation outcomes to the RACMA Board for noting.



Appendices

Medical Administration Specialty Training Program

The Medical Leadership and Management Curriculum focuses on the specific competencies needed for medical management and leadership practice. These competencies are organised around the seven CanMEDS roles.⁵⁸ The central role is that of Medical Leader based on the foundation of medical expertise and supported by competencies embedded in the CanMEDS roles of Communicator, Collaborator, Health Advocate, Manager, Scholar and Professional. The Fellowship Training Program is an integrated learning model divided into four key domains:

- Health system science – addresses ‘the medical expert’.
- Medical management practice – addresses ‘the medical manager’ and ‘the communicator’.
- Research training – addresses ‘the scholar’.
- Personal and professional leadership development – addresses ‘the collaborator’, ‘the advocate’, ‘the professional’ and ‘the leader’.

Each of the Domains incorporates one or more of the RACMA Curriculum’s eight role competencies and has a program of formative assessment activities and summative tasks, including oral examinations, training workshops, webinars, tutorials, written assignments and oral presentations.

The current training program is an advanced program over a minimum of three years 1.0 FTE or six years at 0.5 FTE. Trainees must fulfil all training requirements including an approved Masters degree in a health discipline, 3 x 47 weeks (1.0 FTE) of supervised medical management practice in an accredited training post, research project, self-audit and peer review, learning sets, reflective writing, workshops, and other requirements including the trial oral examinations to be eligible to sit the final oral examination for Fellowship.

Supervision

Candidates have a Primary and Secondary supervisor as well as a preceptor. The Primary supervisor should be a FRACMA and is the direct line manager of the Candidate. If the primary supervisor is not a FRACMA then it is mandatory that a secondary supervisor be identified and that the secondary supervisor is a FRACMA. Depending on the training post, the secondary supervisor may be offsite and will support the Candidate remotely and will work closely with the onsite primary supervisor. Both supervisors provide education, training and ongoing support to Candidates throughout their specialty training. Supervisors of training must participate in supervisor training and undertake any additional training as required. Supervisor training is currently under review as part of the Fellowship Training Program Refresh Project.

Preceptors

A preceptor provides support, education, training, competency development, guidance and advocacy to Candidates undertaking specialty training towards Fellowship. They also have an informal role as mentors. Preceptors are carefully considered and allocated to Candidates according to the level of training of the Candidate. For example, if a trainee has any prior medical administration background prior to commencing specialty medical administration training. Training for Preceptors is under review as part of the Fellowship Training Program Refresh Project.

58 Royal College of Physicians and Surgeons Canada, CanMEDS Framework, <http://www.royalcollege.ca/rcsite/canmeds/canmeds-framework-e>

Jurisdictional Coordinators of Training (JCT)

The role of JCTs in accreditation is to participate on accreditation panels, support Candidates within their jurisdiction by monitoring progress and access to training experiences, organise and support training rotations, support health services in meeting any accreditation recommendations and report any emerging accreditation issues to the AC.

Rotations

Majority of RACMA Candidates hold substantive positions, being positions of employment they hold that have become accredited training posts. Substantive training posts are non-rotational and to ensure that these Candidates have access to all the appropriate workplace experiential training opportunities, they are encouraged and supported to access training experiences outside of their training posts/roles. This can be at either within or external to their organisation and are often informal arrangements.

Approximately one third of Candidates are in registrar training posts that are rotational. Rotations are the responsibility of the JCT and are organised differently per jurisdiction. However, some jurisdictional committees support a centralised rotational model with reference to training gaps identified in each Candidate's annual training plan. In other jurisdictions, Candidates are required to source an accredited training post. Except for WA, who facilitate six monthly rotations, all RACMA registrar training posts are generally 12 to 24 month rotations. A 24 month rotation will be supported for Commonwealth Specialist Training Program (STP) IRTP Integrated Rural Training Pipeline (IRTP) funded posts.

Rotational terms and at what level of training are expressly identified in accreditation recommendations. For example, if a training post is suitable for terms such as:

- All three years of specialty training
- 12 months of specialty training
- 24 month of specialty training.

Levels of training are identified as either first year, second year, third year or all years of training. Usually a large tertiary training hospital will be accredited for a full four year period and all levels of training. Health services with a limited scope of training will have shorter terms of training accredited.

Accreditation Framework

Medical administration training posts are predominantly in health service administration or executive teams of health services. Training can also occur in expanded settings such as Australian Defence Force (ADF), government, government agencies and private health organisations including both health services and insurance. RACMA accredits training posts for the purpose of specialty training in the RACMA Fellowship Training Program for a four year period. A health service may have several training posts however, each post is assessed and reviewed independently of other accredited positions. If a health service has other medical administration training posts, the accreditation panel and AC will consider the history and quality of training previously in the assessment of accreditation.

The advantage of the training program and accreditation of individual training posts is that Candidates may be able to complete most, if not all specialty training in a rural location.

The accreditation framework includes standards, risk matrix, process, regulation, forms and templates that are common for all health settings.



Appendices

The Accreditation of Training Posts Regulation⁵⁹ sets compliance requirements, standards and continuing obligations for the health setting of the training posts that must be met for the RACMA accreditation of training posts.

Granting of accreditation by RACMA will be subject to the training post in a health setting being/having the following:

- A training post for RACMA training in the scope of medical management within an appropriate medical management structure that is conducive to experiential training against the role competencies as defined in the RACMA Medical Leadership and Management Curriculum.
- Appropriate infrastructure enabling the candidate in training access to organisational resources and support, library, organisational information networks and technology.
- Consistent and appropriate supervision where a Supervisor (line-manager) is a senior medical administrator with an appropriate reporting line within a senior medical management framework.
- Stable supervision that fosters a steady and consistent training environment and appropriate support system to the Candidate for the duration of his/her training with RACMA.
- A Policy framework around Human Resources / Industrial Relations support and employee welfare, that is accessible to Candidates in training and provides support and resolution mechanisms as required'.⁶⁰

A risk-based approach has been applied to the accreditation of medical administration training posts. The risk matrix takes into account the quality of the training experience, suitability for levels of training and trainee competence, the breadth and depth of workplace experiential training that can be accessed, supervision, sector (public, private, Indigenous/Maori, government, ADF, etc.), location (metro, regional, rural, remote) and health network opportunities.

For training posts that consistently have reports of high quality training experience, fulfil all workplace experiential training requirements and have a strong RACMA presence as part of supervision, the health setting executive and within the health setting, these are considered to be low-risk posts.

The risk rating increases for training posts that are located regional, rural or remote with limited access to RACMA involved in supporting specialty training. It may be that an accredited training post has an experienced medical manager as the supervisor who is not a RACMA or member of RACMA. Training posts with narrow breadth and depth of workplace experiential training opportunities may be considered higher risk also and this can be the case for training posts in expanded settings outside of metropolitan, public hospitals.

RACMA has moved to post accreditation interviews (site visits) being conducted via Zoom due to the COVID pandemic. Only those positions that may be considered high risk will be considered to have an interview conducted face to face rather than via Zoom.

Accreditation Criteria and Standards

The accreditation criteria and standards cover Candidate wellbeing and support, governance, supervision, supervisor support, workplace training experiences, education and training programs including access to Indigenous and Maori health. See Appendix E1 for further details.

⁵⁹ <https://racma.edu.au/about-us/governance/regulations-and-guidelines/accreditation-of-training-posts/>

⁶⁰ <https://racma.edu.au/about-us/governance/regulations-and-guidelines/accreditation-of-training-posts/>

Accreditation Process and Assessments

Health settings seeking to accredit a new training post and re-accredit a training post must complete an application form and provide all associated documentation to RACMA. The elements a health setting must consider in establishing a post are availability of supervisors, capacity to train, a suitable position description to meet training requirements and organisational policies to support specialty training.

Accreditation applications are received by RACMA at any time throughout the year.

Applications undergo a two-step review: firstly a desktop review, and secondly an interview with key organisational stakeholders as well as the Candidate to assess, verify and validate the suitability of the training post for accreditation.

Desktop Review

The desktop review ensures that the health setting has submitted all the required documentation and meets the accreditation criteria and standards for the commencement of training. A training post will then be awarded Provisional Accreditation which will enable the recruitment of a Candidate to a position or the commencement in training of a substantive Candidate. RACMA will schedule an accreditation interview within 6 months of Provisional Accreditation being granted to assess, verify and validate the accreditation of the training post.

Site Inspections

A health setting will require an accreditation site inspection interview following provisional accreditation, for re-accreditation or as part of a review to regain full accreditation. An accreditation panel will be established (see below) to meet with representatives at the health setting. These interviews generally run over 2 hours. The accreditation panel has a set list of questions and points to cover in each meeting with each stakeholder that are provided to the health setting in advance of the site inspection. The accreditation panel will meet with:

- Chief Executive Officer or Senior Management Representative – this person must be more senior than the supervisor and represent the health setting.
- Supervisors including the line manager and secondary supervisor if the line manager is not a FRACMA – Director of Medical Services / Executive Director Medical Services, Chief Medical Officer, etc.
- Candidate (trainee) – the accreditation panel may also request to meet with other Candidates onsite, if any.

Accreditation Panels

Accreditation panels consist of an external FRACMA to the jurisdiction of the health service being accredited, a local jurisdictional committee FRACMA and a RACMA accreditation staff member. Usually FRACMA are the Jurisdictional Coordinators of Training, however, availability may deem that another FRACMA from the same jurisdictional committee will be requested to participate in the assessment. The composition of each accreditation panel will depend on the jurisdiction, accreditation experience of the FRACMA, contextual and broader training knowledge of the health service being inspected, previous experience as a supervisor, knowledge of the specialty training program, conflict of interest considerations, risk of the training post not being compliant, any issues raised about a particular training post, supervisor and / or site.



Appendices

Training of accreditation panel members occurs during site inspections with new surveyors participating on accreditation panels as observers on selected site visits to build up the pool of available accreditation panel members.

Many FRACMA participate in the accreditation assessment of health services against the NSQHS Standards so RACMA is well placed to access to experienced surveyors.

The chair of accreditation panels will also participate in AC meetings in relation to sites they have inspected to present on the accreditation findings and recommendations identified in the report.

Accreditation Outcomes

All accreditation outcomes are reported by accreditation panels to the AC. Recommendations on accreditation outcomes are made to the AC for endorsement before going to the ETC for approval.

Health service executives and training supervisors are formally notified by RACMA in writing of accreditation outcomes once the ETC has approved the accreditation recommendations.

Provisional Accreditation

A training post is awarded provisional accreditation when it has demonstrated, via a desktop review and signed off by the Chair of the Accreditation Committee. Provisional accreditation is for a period of six months. A site inspection by an accreditation panel is conducted within six months of the provisional accreditation being granted to verify and validate that the training post is demonstrating compliance with the accreditation standards.

Full Accreditation

Following the accreditation site visit, the accreditation panel will write a report and make a recommendation to the AC. A recommendation of full accreditation is awarded to a training post that meets all the accreditation criteria and is to be accredited for the full four year period.

In cases where a substantive training position is being accredited, the position will be granted accreditation for four years or for the term of training, being no more than four years. Once a substantive trainee attains Fellowship, the position is no longer an accredited training post.

Accreditation with Recommendations

A training post may still be awarded accreditation, subject to recommendations being met if there are any gaps that have been identified during the interview process. Recommendations within specified timeframes must be met to become compliant. RACMA will notify the training post of the outcome, including the senior executive and training supervisor of the training post of the accreditation outcome and requirements.

The AC, through the accreditation panels, will monitor the progression of a training post towards meeting compliance and undertake reviews at key milestones to determine if the training post has met requirements. These monitoring checks are carried out by the original accreditation panel.

Accreditation with recommendations is for a maximum period of 12 months, at the end of the period, the AC will determine if it is satisfied that the training post has met all the requirements to attain full

accreditation or if not, accreditation may be withdrawn and the training post de-accredited. RACMA works closely with the health service to assist in remediation of any recommendations that need to be met.

Withdrawal or De-Accreditation

When a training post fails to comply with the minimum requirements for accreditation and/or fails to improve during a review period (such as 'accreditation with recommendations'), the accreditation of the training post will be withdrawn. The training post will be able to re-apply for accreditation after 12 months. RACMA provides support to health services to meet accreditation requirements should they wish to apply for accreditation in the future.

Accreditation Monitoring, Evaluation and Review

RACMA monitors accreditation practices through an online evaluation survey sent to health settings, Candidates and supervisors annually who have been involved in an accreditation site inspection during the previous 12 months. The results of this survey contributes to continuous improvement activities in the accreditation framework.

RACMA undertakes a review of the accreditation framework every three years. The main drivers of change in the accreditation framework will be specialty training program changes, curriculum changes, supervision arrangements, and regulatory changes through the AMC or government programs.

Changes that have occurred over time in accreditation have been the addition of the risk matrix, the introduction of both primary and secondary supervisors to ensure that trainees are well supported in their training, updates and improvements to regulation, policy, templates and practice, stronger guidelines for the accreditation process, the establishment of the AC, surveyor training and systems improvement, such as the development of an online platform.

RACMA conducts annual Candidate and supervisor surveys in relation to the specialty training program. This survey covers all aspects of training and includes elements that feed into accreditation and any continuous improvement measures.

In addition, RACMA undertakes an annual survey of trainees in STP, STP-IRTP and STP TAS funded training posts about their training experiences. The findings from this survey also feed into accreditation.

Accreditation Data Management

RACMA manages accreditation data both in paper and in soft copy. Records are collated in an Excel spreadsheet and this information is also used to carry out the accreditation function, i.e. monitoring, scheduling of accreditation inspections, reviews, etc. RACMA is moving to a purpose-built online platform developed by BPAC that will integrate accreditation within a specialty training management system and provide for CPD maintenance and tracking for members. This project is in progress with the specialty training management system completed. The system will allow for online accreditation data to be accessible from anywhere with login access and enable a move to online forms and accreditation site visit reports.



Appendix E1: RACMA Accreditation Criteria and Standards

Table 5 RACMA Accreditation Criteria and Standards

Accreditation Performance Criteria	Factors Assessed	Minimum Standards
Training Support for Trainees		
1. General educational activities within the health setting	<ul style="list-style-type: none"> Documented medical education program 	<ul style="list-style-type: none"> Candidate has access to the medical education program Evidence of a plan of scheduled education activities
2. Coordinated schedule of learning experiences for each trainee	<ul style="list-style-type: none"> Timetable of activities which incorporate the learning needs of the trainee 	<ul style="list-style-type: none"> Regular and scheduled meetings Regular and scheduled tutorials Meeting log / records
3. Access to external education activities for trainees	<ul style="list-style-type: none"> Document on health setting leave access to support education requirements – EBA, Award, policy Equipment provided for distance learning 	<ul style="list-style-type: none"> Ready access to all components of training, RACMA workshops, education meetings and to complete the requirements of the Master's program either in person or via electronic means For other significant course, modern educational approaches to distance learning e.g. video conferencing
4. Opportunities for research, enquiry and scholarly activity	<ul style="list-style-type: none"> Access to good reference library, online journals, etc. Research project opportunities 	<ul style="list-style-type: none"> Access to good reference library, online journals, etc. Regular scheduled research meetings Access to an appropriate Human Research and Ethics Committee (HREC) Access to resources to participate in research
5. Opportunities for Indigenous / Maori Health training	Access to training in Indigenous or Maori Health	<ul style="list-style-type: none"> Access to Indigenous or Maori Health training onsite Access to Indigenous or Maori Health training offsite
Supervision		
6. Designated supervisor of medical administration training	<ul style="list-style-type: none"> Documentation on supervisor role and organisational chart 	<ul style="list-style-type: none"> Clearly identifiable and named supervisor and reporting lines on organisational chart Suitably experienced supervisor (FRACMA or senior line manager). Supervision is appropriate to the competence level of the trainee Availability of supervision (capacity in the supervisor's schedule) is consistent with the level of supervision required by the trainee.

Accreditation Performance Criteria	Factors Assessed	Minimum Standards
7. Supervisor's role / responsibilities	<ul style="list-style-type: none"> Health setting documentation on supervisor's role and responsibilities in keeping with the college training requirements. 	<ul style="list-style-type: none"> Supervisor is familiar with the RACMA standards and the Medical Leadership and Management Curriculum Supervisor is available to participate in RACMA supervisor's meetings and training Meetings with Preceptor, trainee and JCT (where required) Active participation in the development of training plans and In-Training Assessment (ITA) reports
8. Regular supervision, workplace-based assessment and feedback to trainees	<ul style="list-style-type: none"> Documentation on health setting / department practices relating to supervision, workplace based assessment and feedback to trainees – HR policy on organisational performance review process 	<ul style="list-style-type: none"> Training plan discussed and agreed between supervisor, preceptor and trainee at the commencement of each academic year. ITA Report completion – every 6 months
Organisational Support		
9. Health setting support for supervisor involved in education and training	<ul style="list-style-type: none"> HR policy or documentation on the inclusion of education and training as a component of the role of supervisors and organisational support for supervisors 	<ul style="list-style-type: none"> For the organisation to provide access to CPD and the education and training domain Organisational access to IT Documented process for access to professional development
10. Health setting support for Candidates involved in education and training	<ul style="list-style-type: none"> HR Policy or documentation on the inclusion of education and training / professional development 	<ul style="list-style-type: none"> For the organisation to support and provide access to workplace learning opportunities, suitable for training in the specialty of medical administration Organisational access to IT Documented process for access to professional development
11. Health setting support for Candidate	<ul style="list-style-type: none"> HR Policies for bullying and harassment, discrimination and victimisation 	<ul style="list-style-type: none"> Does the health setting have these policies? Are all staff (including trainees and visiting supervisors) required to adhere to policies? Can trainees utilise the health setting's complaints and dispute procedures if they have a complaint about bullying, harassment, discrimination or victimisation? Access to Employee Assistance Program (EAP)



Appendix F: Royal Australasian College of Physicians (RACP)

The Royal Australasian College of Physicians (RACP) is the leading body for physician education in Australia and New Zealand. The RACP is a not-for-profit organisation which represents a membership of 26,609, of which 23,303 are based in Australia, 3,322 in New Zealand and the remainder overseas. Members include 18,863 Fellows, 8,830 trainee physicians and 150 honorary Fellows. Trainees consist of 5,033 basic trainees and 3,797 advanced trainees as at 31 December 2020.⁶¹

The RACP has two Divisions: Adult Medicine, and Paediatrics and Child Health. All Fellows who hold the FRACP belong to one of the Divisions. The Divisions offer Physician training in a wide variety of medical specialties and administer the continuing professional development program for all Fellows who hold an FRACP.

The Paediatric Division has a Chapter of Community Child Health⁶² and the Adult Medicine Division has Chapters in Addiction Medicine⁶³, Palliative Medicine,⁶⁴ and Sexual Health Medicine.⁶⁵

The RACP has three Faculties in Public Health Medicine,⁶⁶ Rehabilitation Medicine⁶⁷ and Occupational and Environmental Medicine.⁶⁸ A Faculty is an independent body within the RACP, which offers its own vocational training programs. Gaining Fellowship of a Faculty does not confer Fellowship of the RACP. However, training obtained during a Faculty program may go towards training for Fellowship of the RACP and vice versa.

There are also 51 specialty societies affiliated with the RACP. The RACP maintains strong links with these societies in terms of sharing of knowledge and expertise.

The RACP is accredited by the AMC until 31 March 2025.

61 RACP Annual Report 2020, https://www.racp.edu.au/docs/default-source/about/reports-and-notice/2020-racp-annual-report.pdf?sfvrsn=cd02ff1a_14

62 <https://www.racp.edu.au/about/college-structure/paediatrics-child-health-division/chapter-of-community-child-health>

63 <https://www.racp.edu.au/about/college-structure/adult-medicine-division/australasian-chapter-of-addiction-medicine>

64 <https://www.racp.edu.au/about/college-structure/adult-medicine-division/australasian-chapter-of-palliative-medicine>

65 <https://www.racp.edu.au/about/college-structure/adult-medicine-division/australasian-chapter-of-sexual-health-medicine>

66 <https://www.racp.edu.au/about/college-structure/australasian-faculty-of-public-health-medicine>

67 <https://www.racp.edu.au/about/college-structure/australasian-faculty-of-rehabilitation-medicine>

68 <https://www.racp.edu.au/about/college-structure/australasian-faculty-of-occupational-and-environmental-medicine>

College Governance

The RACP is governed by a Board of Directors⁶⁹ including President, President-Elect, President Aotearoa (NZ), two member Directors, two community Directors, an Honorary Treasurer and a Trainee Director.

Accountabilities and responsibilities of the Board are:

- Strategy and Planning
- Performance Monitoring
- Financial Reporting
- Risk Management and Compliance
- Personnel.

The Board has standing committees and bodies that report to it. The committees include:

- College Appeals Committee (ad-hoc)
- College Education Committee
- College Policy and Advocacy Committee
- College Research Committee
- College Standards Committee (ad-hoc)
- College Trainees' Committee
- Ethics Committee
- Fellowship Committee
- Finance and Risk Management Committee
- Remuneration Committee
- Australia and New Zealand Regional Committees.

Other bodies include:

- College Council
- Adult Medicine Division Council
- Paediatrics and Child Health Division Council
- Australasian Faculty of Occupational and Environmental Medicine Council
- Australasian Faculty of Public Health Medicine Council
- Australasian Faculty of Rehabilitation Medicine Council
- RACP Foundation⁷⁰.

69 <https://www.racp.edu.au/about/board-and-governance/racp-board>

70 RACP Role of the Board,
https://www.racp.edu.au/docs/default-source/about/board/role-of-the-board.pdf?sfvrsn=cad0391a_2



Appendices

College Education Committee

The College Education Committee (CEC) is the RACP's peak body responsible for developing and overseeing College-wide education policy and approving both new and amended training and education programs.

The CEC is an expert group acting on behalf of the College Board. It develops policy for all RACP Training Programs in relation to:

- selection into training
- teaching and learning
- assessment
- progression through training including certification of training
- changes to training program requirements
- accreditation of training settings
- appointment, support, and accreditation of supervisors
- continuing professional development
- training and assessment for overseas-trained physicians and specialists⁷¹.

College Council

The College Council was established as the peak advisory body on strategic and cross-college issues. The council responds to issues The Board refers to it and raises issues to the Board that the College Council feels need consideration. College council membership consists of up to 44 Fellows and trainees including:

- A Fellow appointed by the Aotearoa New Zealand Committee
- A representative from each of the 26 identified Education Pathways (including Chapters) within the College
- A Fellow appointed by each RACP Division
- A Fellow appointed by each RACP Faculty
- Four Trainees appointed by the College Trainees' Committee A Fellow appointed by each of the seven Australian Regional Committees
- a Maori representative and an Aboriginal or Torres Strait Islander representative, who may be Fellows, trainees, or non-members of the RACP
- a consumer representative from the RACP appointed Consumer Advisory Group or an approved delegate.

71 RACP By-law, College Education Committee, https://www.racp.edu.au/docs/default-source/about/governance/college-education-committee-by-law.pdf?sfvrsn=a676321a_8

Strategic Plan

The RACP Strategic Plan 2021⁷² focuses on adapting and strengthening operations and delivery to enhance member training, development, safety and advocacy in a COVID-19 world. The plan's focus areas for strategic improvement are:

- Implement governance improvements
- Implement education renewal
- Improve member experience
- Deliver the Indigenous Strategic Framework
- Strengthen people and culture
- Renew and uplift Information and Communication Technology.

Accreditation Governance

A Training Provider Accreditation Policy underpins the accreditation activities of the RACP.⁷³

Oversight of accreditation is a responsibility of the CEC, including the development of policy in relation to accreditation of training settings. It also holds responsibility for ensuring consistent quality of education and training across all college training programs, policies and regulations for training and education programs, providing support to Regional Committees and ensuring the college educational programs continue to be consistent with regulatory requirements of the AMC and Ministerial Council of New Zealand (MCNZ).

The Adult Medicine Division Education Committee (AMDEC) sits under the Adult Medicine Division Council and the Paediatrics & Child Health Division Education Committee (PDEC) sits under the Paediatrics & Child Health Division Council. Both committees also report to the CEC on matters related to education policy and program development and ensure accreditation is conducted fairly and efficiently, in a transparent manner and in accordance with the standards for settings providing divisional Basic and Advanced Training Programs. AMDEC meets four times a year with up to four meetings if required, and PDEC meets three times a year with up to six meetings if required. Both committees have a dedicated member who is allocated the responsibility for accreditation.

Reporting to the Education Committees are training committees which are responsible for the 35 training programs including accreditation of training programs in settings.

Training committees with larger training programs have a dedicated subcommittee to manage accreditation. The delivery of training program accreditation is supported by RACP Staff. Training Committees and accreditation subcommittees are responsible for ongoing accreditation of training programs, initial accreditation, and reclassification of training programs.

⁷² RACP Strategic Plan 2021, https://www.racp.edu.au/docs/default-source/about/strategic-plan-2021.pdf?sfvrsn=301efa1a_2

⁷³ RACP Training Provider Accreditation Policy, 1 January 2020, https://www.racp.edu.au/docs/default-source/about/accreditation/renewal/training-provider-accreditation-policy.pdf?sfvrsn=b4cae91a_6



Physician Training Programs

Specialist training to become a physician commences with Basic Physician Training in either Adult Internal Medicine or Paediatric and Child Health followed by a period of time in Advanced Training, in a chosen subspecialty.

Basic Physician Training – Adult Internal Medicine⁷⁴

Basic Training in Adult Internal Medicine requires three years of fulltime equivalent training. It consists of 24 months of core training and 12 months of non-core training.

Core Training

Core Training includes:

- A minimum of three months and up to 12 months of General Medicine, with no more than six months at any one accredited training site.
- A minimum of 12 months in specialties, with a maximum of six months per specialty, in rotations such as:
 - Cardiology
 - Gastroenterology
 - Neurology
 - Clinical genetics
 - Geriatric medicine
 - Palliative medicine
 - Clinical haematology
 - Infectious diseases
 - Rehabilitation medicine
 - Immunology and allergy
 - Intensive Care
 - Rheumatology
 - Clinical pharmacology
 - Medical oncology
 - Respiratory and sleep medicine
 - Endocrinology
 - Nephrology

To meet the medical specialty requirements, a trainee needs to spend at least 50% of their time in each specialty across two or more of inpatient, consults and/or ambulatory care.

Trainees can undertake optional core training for a maximum of three months in emergency medicine and anaesthetics and/or six months in general paediatrics.

At least 12 months of training needs to occur at a Level 3 Teaching Hospital (Principal Training Program) and at least three months outside a Level 3 Teaching Hospital (Principal Training Program).

⁷⁴ <https://www.racp.edu.au/trainees/basic-training/adult-internal-medicine#program>

Non-Core Training

In non-core training the options are to complete:

- additional core training in general medicine and or medical specialities
- four three-month non-core rotations below or other rotations considered appropriate by the Director of Physician Education Non-Core Training includes:
 - Addiction Medicine
 - Dermatology
 - General practice
 - Medical administration
 - Medical and humanitarian aid organisations⁷⁵
 - Medical education
 - Nuclear medicine
 - Post-acute community care
 - Psychiatry
 - Radiation oncology
 - Supervised clinical research
 - Surgery
- up to six months in emergency medicine, nights, relieving or paediatric medicine
- a combination of the above the options.

Training includes completion of an advanced life support, work-based teaching and learning requirements, and assessments. To be eligible for advanced training, trainees must successfully complete the Divisional Written and Clinical Examinations. Once Basic Training has been completed, a trainee has up to five years to enter Advanced Training.

Basic Physician Training – Paediatric and Child Health⁷⁶

Basic Training in Paediatric and Child Health requires three years of fulltime equivalent, certified training time including work based assessments and learning. It consists of 24 months of core training and 12 months of non-core training.

Core Training

Core training includes:

- A minimum of nine months and up to 27 months in general paediatric medicine
- A minimum of three months and up to 12 months in paediatric emergency medicine
- A minimum of three months in neonatology in a perinatal unit which includes the long-term management of ventilated babies (maximum total of 12 months across both perinatal and non-perinatal units)
- three months minimum in a paediatric medical specialty with a maximum of six months per specialty in rotations such as:
 - Adolescent health
 - Cardiology
 - Clinical genetics
 - Clinical pharmacology
 - Endocrinology
 - Haematology
 - Immunology and allergy
 - Infectious diseases
 - Medical oncology
 - Metabolic
 - Nephrology
 - Neurology
 - Palliative medicine
 - Rehabilitation
 - Respiratory and sleep medicine
 - Rheumatology

At least nine months of training needs to occur at a Level 3 paediatric teaching hospital (Principal Training Program).

⁷⁵ Examples include Médecins Sans Frontières, Red Cross, Royal flying Doctor Service

⁷⁶ <https://www.racp.edu.au/trainees/basic-training/paediatrics-child-health>



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Non-Core Training

In non-core training, the options are to complete:

- Additional corer training in general paediatric medicine, neonatology, paediatric emergency medicine and or paediatric specialities
- a maximum of 12 months of neonatology in a non-perinatal unit
- a maximum of three months in anaesthetics
- a maximum of six months in any of the following rotations:
 - Developmental and psychosocial training
 - Nights
 - Paediatric intensive care
 - Relieving
 - Surgery
- a total of six months⁷⁷ in the following:
 - Adult Medicine Rotations
 - Clinical Improvement Projects
 - Dermatology
 - General Practice
 - Obstetrics and gynaecology
 - Supervised research
- a combination of the above options.

Developmental and Psychosocial Training assists trainees to develop a sophisticated understanding of child development, encompassing physical, cognitive, emotional, behavioural and social areas, which should be gained from the perspective of the child within the family and in the context of the community. This component can be undertaken for up to six months in a rural location with a documented weekly program and appropriate supervision.

Training includes completion of a paediatric life support course, work-based teaching and learning requirements, and assessments. To be eligible for advanced training, the trainees must successfully complete the Divisional Written and Clinical Examinations. Once Basic Training has been completed, a trainee has up to five years to enter Advanced Training.

Advanced Training Programs

The RACP offers 34 subspeciality training programs across the Divisions, Chapters, and Faculties. Each training program has a defined set of training requirements. The details of these requirements can be found on the RACP website under Advanced Training Programs. Links for each program are available in [Appendix F4](#).

⁷⁷ Maximum of three months in dermatology, general practice, and obstetrics and gynaecology

Supervisors

The RACP introduced the Education Leadership and Supervisor Framework in 2018 to drive excellence and promote high quality medical education and training. It identifies:

- roles and structure of educational leadership and supervision
- standards for educational leadership and supervision
- accreditation, selection, and appointment of educators
- evaluation of educational leadership and supervision.

The Educational Leadership and Supervision standards have four domains:

- Quality and Safety
- Learning Environment and Culture
- Teaching and Facilitating Learning
- Educational Leadership and Management.

Each educator role is expected to function according to levels of competence being Foundation, Intermediate and Advanced.

The Framework is currently under review and updates are expected to be provided in 2021.⁷⁸

The RACP has a Supervisor Professional Development Program to support educators in relation to coaching, educational tools and teaching and assessment strategies and advice. There are three workshops that supervisors need to complete before being approved. Supervisors must complete one workshop by the end of 2021 and all remaining workshops by the end of 2022.

This program runs regularly face-to-face or online format workshops. The RACP held 139 and 210 supervisor workshops in 2019 and 2020, respectively.

In 2020, the RACP in collaboration with the Black Dog Institute and University of NSW recruited 200 supervisors who were placed into a randomised controlled trial to test the efficacy of an online mobile responsive education program for physician supervisors to manage the mental health and work environment of physician trainees. The outcomes of the trial are still being finalised.

As part of the Training Provider Standards, the RACP is implementing changes to better support educators:

- funding, staff, and time to complete supervision and educational leadership duties
- measuring the capacity of educators to train
- access to training professional development opportunities
- access to wellbeing, protection from bullying harassment and discrimination
- monitoring of workload, fatigue, and burnout.

78 <https://www.racp.edu.au/fellows/supervision/supervisor-support-and-resources/educational-leadership-and-supervision-framework>



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Basic Training

There are four educator roles for Basic Physician Training:⁷⁹

- **Network Director of Physician/Paediatric Education (NDPE):** A RACP Fellow who provides educational leadership to an integrated Basic Training Program across a network of settings.
- **Director of Physician/Paediatric Education (DPE):** A RACP Fellow who provides leadership and oversight to an Adult Medicine or Paediatrics & Child Health Basic Training Program at a Setting. At the discretion of the Training Provider, there may also be a Deputy DPE.
- **Educational Supervisor:** A RACP Fellow who observes, oversees, and supports trainees with the completion of Training Program requirements, trajectory of learning and longitudinal progression.
- **Rotation Supervisors:** A consultant who oversees a trainee's learning, teaching, learning and assessment on a rotation.
- **Assistant Supervisor:** An Advanced Trainee who under the guidance of a clinical and/or rotation supervisor observes and oversees a trainee's work and/or trainee's learning, teaching, and assessment within a rotation, respectively.

The NDPE and DPE are appointed by the Training Provider and approved by the relevant Divisional Basic Training Program Committee. The Rotation and Education Supervisors are confirmed by the DPE and the RACP is notified of the appointment.

Except for the assistant supervisor role, suggested eligibility, and selection criteria are articulated for each role. The suggested eligibility criteria include number of years post-Fellowship, experience supervising medical training and completion of Supervisor Professional Development Program (SPDP). There is flexibility with respect to Fellows who do not have the requisite number of years post Fellowship. Rotation and education supervisors have up to 12 months to complete the SPDP on commencing the role.

The selection criteria cover understanding the curriculum, training requirements, best practice medical education and principles of adult learning; a commitment to meeting the principles in educational leadership and supervision policy; and a level of competence with respect to the RACP standards for educational leadership and Supervision.

The Basic Training Accreditation Requirements⁸⁰ identifies the FTE equivalency for NDPE and DPEs based on trainee numbers and the ratio of trainees to rotation and education supervisors.

79 RACP Framework for Educational Leadership and Supervision, https://www.racp.edu.au/docs/default-source/fellows/supervision/educational-leadership-and-supervision-framework.pdf?sfvrsn=1bdd3e1a_8

80 <https://www.racp.edu.au/about/accreditation/basic-training/standards-and-requirements>

Advanced Training

There are two educator roles for Advanced Training⁸¹ :

Advanced Training Supervisor: A consultant who oversees a trainee learning, teaching and assessment during a rotation and observes, oversees, and supports trainees with the completion of Training Program requirements, trajectory of learning and longitudinal progression.

Training Program Director: RACP Fellows who provide leadership and oversight to a Training Program. This is a new role and depending on the speciality provide leadership at a setting, network, region, jurisdiction or national level.

Accreditation Program

At the time of this project consultation, the RACP were in a transition phase still using the Standards for the Accreditation of Training Settings developed in 2010 for the accreditation of training providers, working towards the introduction of the new standards for Basic Physician Training in 2021. Feedback from stakeholders predominantly refers to accreditation under the 2010 accreditation framework and this report reflects this incorporating the current and future system.

The RACP accredits Training Providers to deliver Basic and Advanced Physician Training. Accreditation include Training Networks⁸², Settings, training programs and rotations⁸³.

The Training Provider Accreditation Program⁸⁴ has

- an accreditation policy⁸⁵
- a set of Training Providers Standards applicable to clinically based Training Providers⁸⁶.
- A decision-making framework⁸⁷
- accreditation requirements and classification provisions for training programs
- a process for accreditation of a training provider⁸⁸
- processes for managing change of circumstances and potential breach of standards⁸⁹.

81 RACP Framework for Educational Leadership and Supervision, https://www.racp.edu.au/docs/default-source/fellows/supervision/educational-leadership-and-supervision-framework.pdf?sfvrsn=1bdd3e1a_8

82 Timing of network accreditation is yet to be determined.

83 Timing of rotation accreditation is yet to be determined.

84 RACP Training Provider Accreditation Program, https://www.racp.edu.au/docs/default-source/about/accreditation/renewal/training-provider-accreditation-program.pdf?sfvrsn=d20e0e1a_6

85 RACP Training Provider Accreditation Policy, 1 January 2020, https://www.racp.edu.au/docs/default-source/about/accreditation/renewal/training-provider-accreditation-policy.pdf?sfvrsn=b4cae91a_6

86 <https://www.racp.edu.au/about/accreditation/basic-training/standards-and-requirements>

87 Approved by CEC February 2021

88 RACP Accreditation of a Training Provider, v1.3, https://www.racp.edu.au/docs/default-source/about/accreditation/basic-training/accreditation-of-a-training-provider-process.pdf?sfvrsn=fb07f81a_6

89 In draft as of 30 April 2021



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The RACP renewed accreditation program for Setting Accreditation and Basic Training Program accreditation commenced in 2021. The implementation of Basic Training Program Network and Rotation accreditation and quality improvement activities is being determined. The next phase is to develop the accreditation requirements, classification provisions and facilities, services, and work profile framework for each Advanced Training program.

The main changes from the previous program include:

- Inclusion of standards to address all domains of training.
- Movement towards making training providers accountable for training rather than educators.
- Broader outcome-based standards to improve flexibility about how to achieve a criterion.
- Alignment of standards and the accreditation program across the RACP.
- Improved transparency of processes and outcomes.
- Introduction of a confidential educator and trainee surveys to monitor workplace training. De-identified data is reported back to training providers and jurisdictions for continuous improvement.
- Automating the accreditation process to limit burden and collect data so accreditation is monitored between visits.

Accreditation Policy

Training providers will be assessed, accredited, and monitored against the standards, accreditation requirements and classification provisions. Training Providers will be asked to undertake quality improvement. Training Providers must provide trainees with access to a high-quality training experience including supervision; provide appropriate clinical skills, knowledge, structured education, and research opportunities. It is expected that education and training is well supported at health settings beyond achieving fellowship for continuing professional development.

The Training Provider Accreditation Policy⁹⁰ outlines guiding principles and roles and responsibilities that underpin the Training Provider Accreditation Program and support the delivery of physician training through a partnerships arrangement between the RACP and Training Providers.

The RACP sets the curriculum standards and training requirements for its training programs. Training Providers translate the curriculum content into a program of work-based learning that enables trainees to meet training requirements and complete assessments.

Accreditation guiding principles include quality improvement, a focus on training, supportive of patient safety and quality care, flexibility, proportionate, independent, and accountable, transparent, effective, and coordinated, relevant and collaborative.

90 RACP Training Provider Accreditation Policy, 1 January 2020, https://www.racp.edu.au/docs/default-source/about/accreditation/renewal/training-provider-accreditation-policy.pdf?sfvrsn=b4cae91a_6

Training Provider Standards

The Training Provider Standards are outlined in [Appendix F1](#). These criteria are applicable to Training Providers who deliver any RACP clinical based training program.

The Standards are new and incorporate criteria to better support health settings to deliver high-quality and safe specialty training:

- high standards of medical practice and how it evaluates and improves the quality of service
- a system and culture which enables trainees and supervisors to report patient safety concerns
- trainee and supervisor work arrangements must enable the delivery of high quality care
- trainees are assessed for competence before being placed in situations where supervision is reduced or at a distance, and
- Trainees are involved in patient safety and health quality care activities.

The Standards were developed so Training Providers only complete those they are accountable for meeting. It will be possible in the future to assign criteria and requirements to Networks and/or Settings who are taking responsibility for an aspect of a training. To this end, settings offering Basic Training programs with other training program partners are having their accreditation occur within a similar period.

Accreditation Decisions

Training Provider

A Training Provider's accreditation decision⁹¹ contains several components:

- Accreditation determination
- Length of accreditation
- Timing and type of next reviews
- Classification
- Provisos

An accreditation determination can be:

- **Accredited:** An accreditation status given when a Training Provider has demonstrated compliance with the standards. A Training Provider can have recommendations⁹² added to the decision.
- **Accredited with condition:** An accreditation status given when a Training Provider does not have substantial compliance with one or more criteria or requirements. One or more conditions require remediation by the Training Provider in a defined time.
- **Accredited provisionally:** An accreditation status given when a Training Provider has successfully completed initial accreditation and has permission to commence training. Accreditation is provisional on the training meeting the commitments outlined in the initial accreditation report. Where the commitments are not delivered, accreditation can be withdrawn.

91 RACP Accreditation of a Training Provider, v1.3, https://www.racp.edu.au/docs/default-source/about/accreditation/basic-training/accreditation-of-a-training-provider-process.pdf?sfvrsn=fb07f81a_6, page 6

92 A proviso attached to an accreditation decision when a Training Provider has substantial compliance with a standard and improvements are required prior to the next review.



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- **Accredited provisionally with condition:** An accreditation status given when a Training Provider has successfully completed initial accreditation and has permission to commence training. The Training has not substantially complied with one or more criteria and/or requirements.

The Training Provider remediates conditions in the defined time and demonstrates training is meeting the commitments outlined in the initial accreditation report. Where the conditions are not met or the commitments are not delivered, accreditation can be withdrawn.

- **Accreditation not achieved:** A health service seeking initial accreditation does not demonstrate sufficient preparedness and compliance with the standards to commence training.
- **Accreditation withdrawn:** An accreditation status given when a Training Provider has been assessed as having insubstantial compliance with the criteria and/or requirements. The health service cannot offer physician training.

Withdrawal of accreditation is a multi-stage process. The training provider and RACP collaborate to remediate and resolve noncompliance issues prior to any decision to withdraw accreditation.

- **Accreditation lapsed:** An accreditation status given when a Training Provider has not participated in workplace training for an extended period. The health service cannot offer physician training.

Basic Training

A Basic Training Program accreditation decision⁹³ contains several components:

- Accreditation determination
- Length of accreditation
- Timing and type of next reviews
- Classification
- Training Program delivery duration
- Capacity to Train
- Provisos
- Rotations

The accreditation determinations are the same as for a Training Provider.

Proviso Management

The RACP Accreditation Program focuses on whether the training offered is fit for purpose. During the accreditation decision making process, an accreditation committee can determine aspects of training that require improvement. A proviso can be a recommendation or condition.

When selecting the type of proviso, consideration is given to a criterion or requirement:

- compliance expectation
- rating
- importance of the criterion or requirement
- level of consequence.

The RACP is developing a process for managing provisos.

93 RACP Accreditation of a Training Provider, v1.3, https://www.racp.edu.au/docs/default-source/about/accreditation/basic-training/accreditation-of-a-training-provider-process.pdf?sfvrsn=fb07f81a_6, page 6

Recommendation

A recommendation is applied to a criterion and/or requirement when there is:

- an opportunity to make an improvement which will enhance training
- a minor issue which effects compliance with the standards but is not required to be resolved to achieve an accreditation determination of accredited.

The criterion and/or requirement has a rating of “partially met” or “met”.

An accreditation committee assesses a Training Provider’s progress in addressing the recommendation as part of a monitoring.⁹⁴ It decides whether a recommendation has been resolved as part of the Training Provider’s next comprehensive review.

Condition

A condition is applied to a criterion and/or requirement when there is:

- a moderate or major issue which effects compliance with the standards
- a recommendation which has not been met.

The criterion and/or requirement has a rating of “partially met” or “unmet”.

A Training Provider’s accreditation is dependent on it successfully addressing its conditions. A condition is to be addressed within a specific timeframe for accreditation to be maintained.

Training Program Accreditation Requirements

Basic Physician Training – Adult Medicine

The Adult Internal Medicine Basic Training Program Accreditation Requirements are outlined in [Appendix F2](#). The requirements sit under the Training Provider Standards criteria.

Basic Physician Training – Paediatrics & Child Health

The Paediatrics & Child Health Basic Training Program Accreditation Requirements are outlined in [Appendix F3](#). The requirements sit under the Training Provider Standards criteria.

Advanced Physician Training Programs

The link to accreditation requirements for each advanced training program is outlined in [Appendix F4](#). Unlike the basic training program accreditation requirements, they are yet to be reviewed in the Accreditation Renewal Project and remain linked to the Standards for the Accreditation of Training Settings⁹⁵.

94 Not all Training Providers complete a periodic review, those on a limited accreditation period go straight into a comprehensive review.

95 RACP Standards for the Accreditation of Training Settings, https://www.racp.edu.au/docs/default-source/about/accreditation/standards-for-the-accreditation-of-training-settings.pdf?sfvrsn=cd98eb1a_6



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Training Program Classification Provisions

To accommodate the diverse health services providing basic training, the RACP classifies training programs according to classification provisions. Until recently this framework grouped settings according to an accredited level.

Basic Physician Training

As part of Accreditation Renewal, the accreditation classification provisions have been simplified to relate directly to the delivery of Adult Medicine and Paediatric & Child Health Basic Training Programs rather than structures and functions within a health service. This was done to encourage a greater range of health services to participate in training and to support trainee exposure to the variety of medicine practiced.

Programs will be classified as principal (previously Level 2 and 3) and adjunct (previously Level 1) training programs⁹⁶ and according to their involvement in a Training Network. The training program delivery duration will be determined by the breadth and depth of training experiences available. Both basic training programs have the same provisions.

Summary of Basic Training Program Accreditation Classification

Training Provider			
Training Network		No Network	
<ul style="list-style-type: none"> • Training Program oversight • Network Director of Physician/ Paediatric Education (DPE) • Trainee recruitment and rotation allocation 	<ul style="list-style-type: none"> • 36 months of training • Divisional Clinical Exam (DCE) provided for all Trainees • Formal learning program • Progress Review Panel 	<p>Principal Training Program</p> <ul style="list-style-type: none"> • Training Program OPE • Minimum 18 months of training • Training Program committee • Delivers DCE • Trainee recruitment • Rotation allocation • Formal learning program • Progress Review Panel 	<p>Adjunct Training Program</p> <ul style="list-style-type: none"> • Minimum 3 months of training • Maximum 16 months of training • Trainees rotate to the setting • No direct recruitment
<p>Principal Training Program</p> <ul style="list-style-type: none"> • Training Program OPE • Minimum 18 months of training • Training Program committee • Delivers DCE 	<p>Adjunct Training Program</p> <ul style="list-style-type: none"> • Minimum 3 months of training • Maximum 16 months of training • Trainees rotate to the setting 		

96 <https://www.racp.edu.au/about/accreditation/basic-training>

Advanced Physician Training

Accreditation classification provisions for the advanced training programs form part of the next phase of Accreditation Renewal.

Rotations

Prior to the renewal of the Accreditation Program, rotations were not part of Basic Training program accreditation, the process reviewed training programs. Whereas most advanced training programs accredit rotations or posts.

Under the new Training Provider Accreditation Program, rotation descriptions will be introduced, rotation accreditation decisions made, and rotations will be reviewed to ensure appropriate depth and breadth of clinical experiences, supervision, feedback and assessment. The rotation descriptions will be captured in a new online data management system currently in development.⁹⁷

Accreditation Process and Reviews

Accreditation applications are received by the RACP throughout the year. This includes applying to become an accredited training provider, having their status as a training provider renewed and/or seeking a reclassification of their training program.

The RACP has a process for the accreditation of a Training Provider on its website⁹⁸.

The process involves:

1. **Self-assessment** – involves a Training Provider reflecting on their compliance with the Standards, preparing a written response to describe this compliance, rating its performance, and providing supporting documentation to substantiate the response.
2. **External assessment** – involves an Accreditation Review Panel assessing the Training Provider's compliance with the Standards. The assessment encompasses tours and interviews with people associated with the Training Provider's training governance and physician training programs such as trainees, supervisors, Network and Training Program Directors, Director of Medical Services/ Chief Medical Officer. There may also be an interview with the senior executive of the health setting/s. This may take anywhere from half a day to several days, depending on the intensity of the training program and number of sites involved in the accreditation. The Panel outlines its preliminary findings to the Training Provider at a summation meeting and submits an external assessment report to the RACP.
3. **External validation** – involves an Accreditation Committee determining a Training Provider's accreditation decision.
4. **Reporting** – involves the RACP releasing the accreditation report including accreditation decision to a Training Provider and placing the decision onto the RACP website.
5. **Monitoring** – involves the RACP monitoring a Training Provider to ensure ongoing compliance with the standards, progression with recommendations and quality initiatives.

⁹⁷ RACP Interview with DOH transcript, December 2019

⁹⁸ https://www.racp.edu.au/docs/default-source/about/accreditation/basic-training/accreditation-of-a-training-provider-process.pdf?sfvrsn=fb07f81a_6



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The time taken to accredit is dependent on

- the nature of what is being accredited: a setting, network, training program and/or rotation
- availability of an accreditation review panel
- capacity of the committee with responsibility for accreditation. Committees meet four to six times per year.

To provide improved clarity, the RACP has identified the time it takes to move through the cycle stages and developed a schedule which outlines when a Setting will have their accreditation review. The RACP is moving towards a single accreditation review for all training programs.

The RACP conducts workshops and provides individual support for Training Providers preparing for an accreditation review.

Initial Accreditation

Accreditation applications for initial accreditation are received by the RACP throughout the year. A focus review is undertaken, and it involves a document assessment and/or a physical or virtual visit.

Ongoing Accreditation

Accreditation occurs every four years unless it is deemed necessary at an earlier time by an accreditation committee. A comprehensive review is undertaken, and it can involve a document assessment or a physical or virtual visit.

Reclassification

Accreditation applications for reclassification of a training program are received by the RACP throughout the year. A focus review is undertaken, and it involves a document assessment and/or a physical or virtual visit.

Monitoring Accredited Training

The accreditation cycle contains a monitoring stage. This ensures a Training Provider maintains compliance with the standards and progresses its recommendations. It involves the completion of periodic reviews between two comprehensive reviews. Two processes are in draft which will support the monitoring process

- **Change of circumstances:** Changes in health services occur regularly. Training Provider will be required to document and notify the RACP of any changes which may affect training and/or their accreditation status.
- **Reported breach of training provider standards:** The RACP will accept concerns about the quality of training which potentially breach the RACP Training Provider Standards. Concerns could be made in writing and investigated by the RACP. If the breach is substantiated changes can be made to a Training Provider's accreditation status.

The RACP has an annual physician training survey whose questions are directly linked to the Training Provider Standards. The questions are grouped into indicators which enables Training Providers to compare their performance against other like Training Providers.

Accreditation Review Panels

At a minimum, an accreditation review panel contains two Fellows per Basic Training Program, an observer (if assigned) and accreditation team staff. The RACP will be looking at expanding panels to include other members such as trainees with expertise on the Training Programs, Medical Administrators, educationalists, and jurisdictional representatives.

The panel's size composition is determined by the size of the Training Provider, the number of Training Programs it has and whether other Settings and/or Networks are being accredited at the same time. Factors which influence selection onto a panel include accreditation experience, conflict of interest and committee membership.

At the time of the consultation in 2019, the RACP did not run formal accreditation assessor training. Under the new framework, the RACP conducts accreditor workshops. The recruitment and retention of sufficient accreditors is a significant risk to the accreditation program

Accredited Training Settings

The RACP currently has 410 accredited training settings in Australia⁹⁹ accredited on a four-year cycle. Full details of accredited training sites for both basic and advanced training can be found on the RACP website.¹⁰⁰

Accreditation Monitoring, Evaluation and Review

The RACP does not have an evaluation mechanism for its current accreditation program. However, the new accreditation program includes an evaluation process where training providers can evaluate accreditation practices, including visits by accreditation review panels.

The RACP reviews its accreditation program every five years. The current review has been in progress for several years. Implementation of the first phase commenced in 2021 with the accreditation of health services offering training programs in Adult Internal Medicine and Paediatrics & Child Health Medicine Basic Physician Training.

Accreditation Data Management

The RACP uses a combination of manual and electronic data management systems.

With the implementation of the new accreditation program, the RACP is developing a purpose-built IT system with BPAC to automate the accreditation program, improve data collection, monitoring accreditation reporting and accreditation workflows. This will result in efficiencies for the RACP and health services. This system will align with the new Training Provider Accreditation Program.¹⁰¹

99 RACP Annual Report 2019, https://www.racp.edu.au/docs/default-source/default-document-library/racp-annual-report-2019.pdf?sfvrsn=33fbeb1a_4

100 <https://www.racp.edu.au/trainees/accredited-sites>

101 RACP Interview with DOH transcript, December 2019



Appendix F1: RACP Training Provider Standards

The below table summarises the Training Provider Standards. The standards can be accessed on the RACP website.¹⁰²

Table 6

Theme: Environment and Culture	
Standard 1 Safety and Quality	
The environment and culture encourage safety promoting behaviours and support the delivery of high-quality patient and population centred care.	
Setting Criteria	
1.1	The Setting has a high standard of medical practice, evaluates its practices, and improves the quality of its service.
1.2	The Setting has a system and culture that enables issues to be raised about the standard of care without fear of consequence.
1.3	A trainee receives an orientation to each new Setting and rotation.
1.4	Trainee and educator work arrangements enables the delivery of high-quality care and optimises learning and wellbeing.
1.5	Handover occurs when there is a transition in care.
Standard 2 Learning Environment	
The environment and culture value learning and support training.	
Training Provider Criteria	
2.1	Physicians embody the professional standards set out in the RACP Professional Practice Framework and are prepared to be involved in the training, education, and assessment of trainees.
2.2	The Training Provider seeks and responds to concerns about training from trainees and educators.
Setting Criteria	
2.3	The Setting has a learning environment and culture which values, supports, and delivers equitable physician training.
2.4	The Setting provides a safe, respectful learning environment and addresses any behaviour that undermines self and/or professional confidence as soon as it is evident.
2.5	The Setting maximises the educational value of tasks assigned to a trainee.

¹⁰² RACP Training Provider Standards for Clinical Training Programs, https://www.racp.edu.au/docs/default-source/about/accreditation/basic-training/bt-training-provider-standards-clinical-training-programs.pdf?sfvrsn=391fc91a_12

Theme: Training Oversight

Standard 3 Governance

The Training Provider has a systematic approach to training responsibilities and relationships.

Training Provider Criteria

- 3.1 The Training Provider is committed to and responsible for supporting and delivering physician training.
- 3.2 The Training Provider has a training governance system which guides and oversees physician training.
- 3.3 The Training Provider has determined the number of trainees it has in relation to its capacity to resource training and ability to deliver work and training experiences that align with the curricula.
- 3.4 The Training Provider collaborates and has effective relationships with trainees, educators, other Training Providers and the RACP.
- 3.5 The Training Provider has an agreement with the RACP and other Training Providers with whom they work with to deliver training.

Setting Criteria

- 3.6 The Setting assesses the impact service change will have on training and engages with educators and trainees on the change process.

Standard 4 Training Management

The Training Provider manages staff, resources and structures to deliver best practice training.

Training Provider Criteria

- 4.1 The Training Provider has a physician-led structure with the authority, time, funding, and staff to plan, administer and deliver physician training.
- 4.2 The Training Provider has educational resources to support training.
- 4.3 The Training Provider monitors and evaluates training to meet the Standards and improve training quality.
- 4.4 The Training Provider communicates its clinical services and training opportunities.
- 4.5 Trainee recruitment, selection and appointment is fair, rigorous, documented, and transparent.

Setting Criteria

- 4.6 Trainee rosters are accurate, fair, flexible, and timely.
- 4.7 A trainee has a designated workspace, secure space for personal items and a space to relax and study.
- 4.8 A trainee is provided with clean, safe, and private accommodation.



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Theme: Training Support

Standard 5 Educator Leadership, Support and Wellbeing

Educators are skilled and supported in their teaching and leadership roles.

Training Provider Criteria

- 5.1 An educator is selected, inducted, trained, appraised, and recognised.
- 5.2 An educator has the capacity to train and lead.
- 5.3 An educator is supported to maintain health and wellbeing and seek help if needed.

Standard 6 Trainee Support and Wellbeing

Trainees receive a fair, positive and supportive training experience.

Training Provider Criteria

- 6.1 A trainee is supported to maintain health and wellbeing and seek help if needed.
- 6.2 A trainee receives pastoral care, career advice, and information and support to transition between training stages, and to return to training following a career break.
- 6.3 The Training Provider facilitates identification of mentors for trainees.
- 6.4 A trainee has access to flexible work arrangements in accordance with the RACP's *Flexible Training Policy*.

Theme: Curriculum Implementation

Standard 7 Curriculum Delivery

The curriculum is implemented so trainees can achieve the learning outcomes and become independent skilled physicians.

Training Provider Criteria

- 7.1 The Training Program delivers experiential, social, and formal learning which provides a trainee with opportunities to increase their professional responsibility and achieve curriculum learning outcomes.
- 7.2 A trainee receives an induction to the Training Program which explains the curriculum, training requirements, rotations, and the formal learning program.
- 7.3 A trainee is offered training experiences including technology enhanced training, supervisory responsibilities, quality and safety activities, projects, research, and teaching.
- 7.4 A trainee receives cultural safety training.

Setting Criteria

- 7.5 A rotation has a workload, profile of work, access to clinical services and supervision to enable a trainee to receive a breadth and depth of learning opportunities consistent with the curriculum.
- 7.6 Patient rounds and appointments are undertaken at times that facilitate patient-based teaching, completion of trainee duties and attendance at formal learning.
- 7.7 A trainee has protected time for formal learning.

Network Criteria

- 7.8 The Training Network delivers an Integrated Training Program which provides a trainee with the necessary work experiences and learning opportunities required to successfully complete the Training Program.

Theme: Curriculum Implementation

Standard 8 Supervision

A high standard of supervision is always provided to trainees

Training Provider Criteria

8.1 The Training Provider establishes a trainee has accessible, timely and supportive supervision for all aspects of training whilst recognising the principle of increasing professional responsibility.

Setting Criteria

8.2 Supervision arrangements are outlined to the trainee.

8.3 Supervision is provided by a sufficient number of qualified and skilled medical staff with an appropriate level of training and experience.

8.4 The supervisor determines the trainee's level of competence and confidence and provides the trainee with responsibilities and supervision appropriate to their level.

Standard 9 Feedback and Assessment

Trainees receive effective feedback and robust assessment

Training Provider Criteria

9.1 The Training Provider establishes that a trainee's learning plan maps to the curriculum.

9.2 The Training Provider delivers trainee work-based assessments.

9.3 The Training Provider supports trainees to successfully complete their RACP assessments.

9.4 The Training Provider regularly monitors a trainee's performance and assesses their longitudinal progression by observing their patient care, taking account of work-based assessments, and obtaining informal and formal feedback from supervisors

9.5 The Training Provider has a clear process to identify, manage and support a trainee where there is a concern about their performance, progression, professionalism, or conduct.

Setting Criteria

9.6 A trainee receives constructive informal and formal feedback on their performance and is supported to act on it.

9.7 A supervisor providing feedback or performing an assessment has expertise in delivering feedback, the area being assessed and the assessment tool, acts honestly, and can justify their statements and decision.



Appendix F2: Basic Physician Training – Adult Internal Medicine Accreditation Requirements

The below table summarises the Adult Internal Medicine Basic Training Accreditation requirements. Notes accompany most requirements. The requirements can be accessed on the RACP website.¹⁰³

Table 7

Theme: Environment and Culture

Standard 1 Safety and Quality

The environment and culture encourage safety promoting behaviours and support the delivery of high-quality patient and population centred care.

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| 1.1 The Setting has a high standard of medical practice, evaluates its practices, and improves the quality of its service. | 1.1.1 An Adult Internal Medicine Basic Trainee is involved in patient safety and health quality care activities undertaken by the setting. |
| 1.2 The Setting has a system and culture that enables issues to be raised about the standard of care without fear of consequence. | |
| 1.3 A trainee receives an orientation to each new Setting and rotation. | 1.3.1 The setting ensures an Adult Internal Medicine Basic Trainee completes an adult advanced life support course and is oriented to the setting's life support protocols. |
| 1.4 Trainee and educator work arrangements enables the delivery of high-quality care and optimises learning and wellbeing. | |
| 1.5 Handover occurs when there is a transition in care. | 1.5.1 Consultant supported handover occurs at least daily. |

Standard 2 Learning Environment

The environment and culture value learning and support training.

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| 2.1 Physicians embody the professional standards set out in the RACP Professional Practice Framework and are prepared to be involved in the training, education, and assessment of trainees. |
| 2.2 The Training Provider seeks and responds to concerns about training from trainees and educators. |

¹⁰³ RACP Basic Training Accreditation Requirements for Adult Internal Medicine, https://www.racp.edu.au/docs/default-source/about/accreditation/basic-training/bt-accreditation-requirements-aim.pdf?sfvrsn=91fc91a_8

2.3 The Setting has a learning environment and culture which values, supports, and delivers equitable physician training.

2.4 The Setting provides a safe, respectful learning environment and addresses any behaviour that undermines self and/or professional confidence as soon as it is evident.

2.5 The Setting maximises the educational value of tasks assigned to a trainee.

Theme: Training Oversight

Standard 3 Governance

The Training Provider has a systematic approach to training responsibilities and relationships.

3.1 The Training Provider is committed to and responsible for supporting and delivering physician training.

3.2 The Training Provider has a training governance system which guides and oversees physician training.

3.2.1 A Training Program is led by a Director of Physician Education (DPE)¹⁰⁴, who is an RACP Fellow.

3.3 The Training Provider has determined the number of trainees it has in relation to its capacity to resource training and ability to deliver work and training experiences that align with the curricula.

3.3.1 The number of Basic Trainees allocated to a rotation does not exceed the rotation's capacity to train.

3.4 The Training Provider collaborates and has effective relationships with trainees, educators, other Training Providers and the RACP.

3.5 The Training Provider has an agreement with the RACP and other Training Providers with whom they work with to deliver training.

3.6 The Setting assesses the impact service change will have on training and engages with educators and trainees on the change process.

Training Management

3.7 The Training Provider manages staff, resources and structures to deliver best practice training.

104 DPE: Director of Physician Education refers to both a setting and network.



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| <p>3.8 The Training Provider has a physician-led structure with the authority, time, funding, and staff to plan, administer and deliver physician training.</p> <p>3.8.1 Time, funding and staff is given to a Director of Physician Education to complete their responsibility of delivering the Training Program.</p> | <p>3.8.2 The Training Provider ensures an Adult Internal Medicine Basic Trainee has Clinical Supervisors and a designated Rotation and Education Supervisor in accordance with the RACP Basic Training Learning, Teaching, and Assessment Program.</p> |
| <p>3.9 The Training Provider has educational resources to support training.</p> | |
| <p>3.10 The Training Provider monitors and evaluates training to meet the Standards and improve training quality.</p> | |
| <p>3.11 The Training Provider communicates its clinical services and training opportunities.</p> | |
| <p>3.12 Trainee recruitment, selection and appointment is fair, rigorous, documented, and transparent.</p> | <p>3.12.1 The Training Provider ensures applicants selected for the Adult Internal Medicine Basic Training Program meet the selection criteria.</p> |
| <p>3.13 Trainee rosters are accurate, fair, flexible, and timely.</p> | |
| <p>3.14 A trainee has a designated workspace, secure space for personal items and a space to relax and study.</p> | |
| <p>3.15 A trainee is provided with clean, safe, and private accommodation.</p> | |

Theme: Training Support

Educator Leadership, Support and Wellbeing

Educators are skilled and supported in their teaching and leadership roles.

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| <p>3.16 An educator is selected, inducted, trained, appraised, and recognised.</p> | <p>3.16.1 The Training Provider ensures Educators have completed all the RACP Supervisor Professional Development Program Modules.</p> |
| <p>3.17 An educator has the capacity to train and lead.</p> | <p>3.17.1 A Rotation Supervisor can supervise a maximum of three Basic Trainees and an Education Supervisor can supervise a maximum of five Basic Trainees at any one time. When a supervisor is both a Rotation and Education Supervisor, the maximum number of trainees supported is six.</p> <p>3.17.2 Rotation and Education Supervisors are allocated time to complete their supervisory responsibilities.</p> |
| <p>3.18 An educator is supported to maintain health and wellbeing and seek help if needed.</p> | |

Trainee Support and Wellbeing

- 3.19 Trainees receive a fair, positive and supportive training experience.
- 3.20 A trainee is supported to maintain health and wellbeing and seek help if needed.
- 3.21 A trainee receives pastoral care, career advice, and information and support to transition between training stages, and to return to training following a career break.
- 3.22 The Training Provider facilitates identification of mentors for trainees.
- 3.23 A trainee has access to flexible work arrangements in accordance with the RACP's *Flexible Training Policy*.

Theme: Curriculum Implementation

Standard 4 Curriculum Delivery
 The curriculum is implemented so trainees can achieve the learning outcomes and become independent skilled physicians.

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| <ul style="list-style-type: none"> 4.1 The Training Program delivers experiential, social, and formal learning which provides a trainee with opportunities to increase their professional responsibility and achieve curriculum learning outcomes. <ul style="list-style-type: none"> 4.1.1 The Training Provider provides experiential, social and formal learning opportunities which align to the Adult Internal Medicine Basic Training Program Curriculum. | <ul style="list-style-type: none"> 4.1.2 The Training Provider ensures a trainee's rotations align to the clinical experience requirements outlined in the Adult Internal Medicine Basic Training Program Curriculum. 4.1.3 The Training Provider enables a trainee to complete the required and recommended formal learning courses identified for each Phase of the Adult Internal Medicine Basic Training Program Curriculum. |
| <ul style="list-style-type: none"> 4.2 A trainee receives an induction to the Training Program which explains the curriculum, training requirements, rotations, and the formal learning program. | <ul style="list-style-type: none"> 4.2.1 The Training Provider provides an induction to the Training Program to a trainee within two weeks of commencing the Foundation phase of training. |
| <ul style="list-style-type: none"> 4.3 A trainee is offered training experiences including technology enhanced training, supervisory responsibilities, quality and safety activities, projects, research, and teaching. | |
| <ul style="list-style-type: none"> 4.4 A trainee receives cultural safety training. | |
| <ul style="list-style-type: none"> 4.5 A rotation has a workload, profile of work, access to clinical services and supervision to enable a trainee to receive a breadth and depth of learning opportunities consistent with the curriculum. | <ul style="list-style-type: none"> 4.5.1 The Training Setting is required to have the Adult Internal Medicine Basic Training rotations it offers prospectively accredited by the RACP. 4.5.2 The Training Setting ensures a rotation has formal learning opportunities aligned to the responsibilities required by the Department's clinical service. |



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4.6 Patient rounds and appointments are undertaken at times that facilitate patient-based teaching, completion of trainee duties and attendance at formal learning.

4.7 A trainee has protected time for formal learning.

4.7.1 The Training Setting provides a minimum of four hours of formal learning per week with two hours being protected.

4.8 The Training Network delivers an Integrated Training Program which provides a trainee with the necessary work experiences and learning opportunities required to successfully complete the Training Program.

Standard 5 Supervision

A high standard of supervision is always provided to trainees

5.1 The Training Provider establishes a trainee has accessible, timely and supportive supervision for all aspects of training whilst recognising the principle of increasing professional responsibility.

5.1.1 The Training Setting provides accessible clinical supervision 100% of the time a trainee provides service.

5.1.2 The Training Setting ensures there is onsite clinical supervision in an ambulatory setting when a Basic Trainee provides service.

5.2 Supervision arrangements are outlined to the trainee.

5.3 Supervision is provided by a sufficient number of qualified and skilled medical staff with an appropriate level of training and experience.

5.4 The supervisor determines the trainee's level of competence and confidence and provides the trainee with responsibilities and supervision appropriate to their level.

Standard 6 Feedback and Assessment

6.1 Trainees receive effective feedback and robust assessment

6.2 The Training Provider establishes that a trainee's learning plan maps to the curriculum.

6.2.1 The Training Provider facilitates trainee completion of their Rotation Plans, Phase Plans Learning Captures, Observation Captures, Rotation Report and Progress Reports.

6.3 The Training Provider delivers trainee work-based assessments.

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| 6.4 The Training Provider supports trainees to successfully complete their RACP assessments. | 6.4.1 The Training Provider provides examination preparation activities for a trainee eligible to sit the RACP Written and Clinical Examinations. |
| | 6.4.2 The Training Provider offers clinical examination placements equal to or greater than the number of trainees it has who are eligible for the clinical examination. |
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| 6.5 The Training Provider regularly monitors a trainee's performance and assesses their longitudinal progression by observing their patient care, taking account of work-based assessments, and obtaining informal and formal feedback from supervisors | 6.5.1 The Training Provider ensures sufficient meetings are undertaken between a trainee and their supervisors to accurately determine the trainee's learning goals and to measure their performance and progress. |
| | 6.5.2 The Training Provider uses Progress Review Panels to monitor a trainee's performance, determine a trainee's progression status and their completion of the Training Program. |
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- 6.6 The Training Provider has a clear process to identify, manage and support a trainee where there is a concern about their performance, progression, professionalism, or conduct.
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- 6.7 A trainee receives constructive informal and formal feedback on their performance and is supported to act on it.
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- 6.8 A supervisor providing feedback or performing an assessment has expertise in delivering feedback, the area being assessed and the assessment tool, acts honestly, and can justify their statements and decision.



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Appendix F3: Basic Physician Training – Paediatrics & Child Health Accreditation Requirements

The below table summarises the Paediatrics & Child Health Basic Training Accreditation Requirements. Notes accompany most requirements. The requirements can be accessed on the RACP website.¹⁰⁵

Table 8

Theme: Environment and Culture	
Standard 1 Safety and Quality	
The environment and culture encourage safety promoting behaviours and support the delivery of high-quality patient and population centred care.	
1.1 The Setting has a high standard of medical practice, evaluates its practices, and improves the quality of its service.	1.1.1 A Paediatrics & Child Health Basic Trainee is involved in patient safety and health quality care activities undertaken by the training setting.
1.2 The Setting has a system and culture that enables issues to be raised about the standard of care without fear of consequence.	
1.3 A trainee receives an orientation to each new Setting and rotation.	1.3.1 The Training Setting ensures a Paediatrics & Child Health Basic Trainee completes a paediatric advanced life support course and is oriented to the setting's life support protocols.
1.4 Trainee and educator work arrangements enables the delivery of high-quality care and optimises learning and wellbeing.	
1.5 Handover occurs when there is a transition in care.	1.5.1 Consultant supported handover occurs at least daily.
Standard 2 Learning Environment	
The environment and culture value learning and support training.	
2.1 Physicians embody the professional standards set out in the RACP Professional Practice Framework and are prepared to be involved in the training, education, and assessment of trainees.	
2.2 The Training Provider seeks and responds to concerns about training from trainees and educators.	
2.3 The Setting has a learning environment and culture which values, supports, and delivers equitable physician training.	
2.4 The Setting provides a safe, respectful learning environment and addresses any behaviour that undermines self and/or professional confidence as soon as it is evident.	
2.5 The Setting maximises the educational value of tasks assigned to a trainee.	

¹⁰⁵ RACP Basic Training Accreditation Requirements for Paediatrics and Child Health, https://www.racp.edu.au/docs/default-source/about/accreditation/basic-training/bt-accreditation-requirements-pch.pdf?sfvrsn=691fc91a_10

Theme: Training Oversight

Standard 3 Governance

The Training Provider has a systematic approach to training responsibilities and relationships.

- 3.1 The Training Provider is committed to and responsible for supporting and delivering physician training.

- 3.2 The Training Provider has a training governance system which guides and oversees physician training.
 - 3.2.1 A Training Program is led by a Director of Paediatric Education (DPE)¹⁰⁶, who is an RACP Fellow.

- 3.3 The Training Provider has determined the number of trainees it has in relation to its capacity to resource training and ability to deliver work and training experiences that align with the curricula.
 - 3.3.1 The number of Basic Trainees allocated to a rotation does not exceed the rotation’s capacity to train.

- 3.4 The Training Provider collaborates and has effective relationships with trainees, educators, other Training Providers and the RACP.

- 3.5 The Training Provider has an agreement with the RACP and other Training Providers with whom they work with to deliver training.

- 3.6 The Setting assesses the impact service change will have on training and engages with educators and trainees on the change process.

Standard 4 Training Management

The Training Provider manages staff, resources, and structures to deliver best practice training.

- 4.1 The Training Provider has a physician-led structure with the authority, time, funding, and staff to plan, administer and deliver physician training.
 - 4.1.1 Time, funding, and staff is given to a Director of Paediatric Education to complete their responsibility of delivering the Training Program.
 - 4.1.2 The Training Provider ensures a Paediatrics & Child Health Basic Trainee has Clinical Supervisors and a designated Rotation and Education Supervisor in accordance with the RACP Basic Training Learning, Teaching, and Assessment Program.

- 4.2 The Training Provider has educational resources to support training.

- 4.3 The Training Provider monitors and evaluates training to meet the Standards and improve training quality.

- 4.4 The Training Provider communicates its clinical services and training opportunities.

106 DPE: Director of Physician Education refers to both a setting and network.



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Theme: Training Oversight

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| 4.5 Trainee recruitment, selection and appointment is fair, rigorous, documented, and transparent. | 4.5.1 The Training Provider ensures applicants selected for the Paediatrics & Child Health Training Program meet the selection criteria. |
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| 4.6 Trainee rosters are accurate, fair, flexible, and timely. | |
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| 4.7 A trainee has a designated workspace, secure space for personal items and a space to relax and study. | |
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| 4.8 A trainee is provided with clean, safe, and private accommodation. | |

Theme: Training Support

Standard 5 Educator Leadership, Support and Wellbeing

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| 5.1 Educators are skilled and supported in their teaching and leadership roles. | |
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| 5.2 An educator is selected, inducted, trained, appraised, and recognised. | 5.2.1 The Training Provider ensures Educators have completed all the RACP Supervisor Professional Development Program Modules. |
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| 5.3 An educator has the capacity to train and lead. | 5.3.1 A Rotation Supervisor can supervise a maximum of three Basic Trainees and an Education Supervisor can supervise a maximum of five Basic Trainees at any one time. When a supervisor is both a Rotation and Education Supervisor, the maximum number of trainees supported is six. |
| | 5.3.2 Rotation and Education Supervisors are allocated time to complete their supervisory responsibilities. |
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| 5.4 An educator is supported to maintain health and wellbeing and seek help if needed. | |

Standard 6 Trainee Support and Wellbeing

Trainees receive a fair, positive and supportive training experience.

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| 6.1 A trainee is supported to maintain health and wellbeing and seek help if needed. | |
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| 6.2 A trainee receives pastoral care, career advice, and information and support to transition between training stages, and to return to training following a career break. | |
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| 6.3 The Training Provider facilitates identification of mentors for trainees. | |
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| 6.4 A trainee has access to flexible work arrangements in accordance with the RACP's <i>Flexible Training Policy</i> . | |

Theme: Curriculum Implementation

Standard 7 Curriculum Delivery

The curriculum is implemented so trainees can achieve the learning outcomes and become independent skilled physicians.

7.1 The Training Program delivers experiential, social, and formal learning which provides a trainee with opportunities to increase their professional responsibility and achieve curriculum learning outcomes.	7.1.1 The Training Provider provides experiential, social and formal learning opportunities which align to the Paediatrics & Child Health Training Program Curriculum.
	7.1.2 The Training Provider ensures a trainee's rotations align to the clinical experience requirements outlined in the Paediatrics & Child Health Basic Training Program Curriculum.
	7.1.3 The Training Provider enables a trainee to complete the required and recommended formal learning courses identified for each Phase of the Paediatrics & Child Health Basic Training Program Curriculum.
7.2 A trainee receives an induction to the Training Program which explains the curriculum, training requirements, rotations, and the formal learning program.	7.2.1 The Training Provider provides an induction to the Training Program to a trainee within two weeks of commencing the Foundation phase of training.
7.3 A trainee is offered training experiences including technology enhanced training, supervisory responsibilities, quality and safety activities, projects, research, and teaching.	
7.4 A trainee receives cultural safety training.	
7.5 A rotation has a workload, profile of work, access to clinical services and supervision to enable a trainee to receive a breadth and depth of learning opportunities consistent with the curriculum.	7.5.1 The Training Setting is required to have the Paediatric & Child Health Basic Training rotations it offers prospectively accredited by the RACP.
	7.5.2 The Training Setting ensures a rotation has formal learning opportunities aligned to the responsibilities required by the Department's clinical service.
7.6 Patient rounds and appointments are undertaken at times that facilitate patient-based teaching, completion of trainee duties and attendance at formal learning.	
7.7 A trainee has protected time for formal learning.	7.7.1 The Training Setting provides a minimum of four hours of formal learning per week with two hours being protected.



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Theme: Curriculum Implementation

7.8 The Training Network delivers an Integrated Training Program which provides a trainee with the necessary work experiences and learning opportunities required to successfully complete the Training Program.

Standard 8 Supervision

A high standard of supervision is always provided to trainees

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|---|---|
| 8.1 The Training Provider establishes a trainee has accessible, timely and supportive supervision for all aspects of training whilst recognising the principle of increasing professional responsibility. | 8.1.1 The Training Setting provides accessible clinical supervision 100% of the time a trainee provides service. |
| | 8.1.2 The Training Setting ensures there is onsite clinical supervision in an ambulatory setting when a Basic Trainee provides service. |

8.2 Supervision arrangements are outlined to the trainee.

8.3 Supervision is provided by a sufficient number of qualified and skilled medical staff with an appropriate level of training and experience.

8.4 The supervisor determines the trainee's level of competence and confidence and provides the trainee with responsibilities and supervision appropriate to their level.

Standard 9 Feedback and Assessment

Trainees receive effective feedback and robust assessment

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| 9.1 The Training Provider establishes that a trainee's learning plan maps to the curriculum. | 9.1.1 The Training Provider facilitates trainee completion of their Rotation Plans, Phase Plans Learning Captures, Observation Captures, Rotation Report and Progress Reports. |
| 9.2 The Training Provider delivers trainee work-based assessments. | |
| 9.3 The Training Provider supports trainees to successfully complete their RACP assessments. | 9.3.1 The Training Provider provides examination preparation activities for a trainee eligible to sit the RACP Written and Clinical Examinations. |
| | 9.3.2 The Training Provider offers clinical examination placements equal to or greater than the number of trainees it has who are eligible for the clinical examination. |

Theme: Curriculum Implementation

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| <p>9.4 The Training Provider regularly monitors a trainee's performance and assesses their longitudinal progression by observing their patient care, taking account of work-based assessments, and obtaining informal and formal feedback from supervisors</p> | <p>9.4.1 The Training Provider ensures sufficient meetings are undertaken between a trainee and their supervisors to accurately determine the trainee's learning goals and to measure their performance and progress.</p> <p>9.4.2 The Training Provider uses Progress Review Panels to monitor a trainee's performance, determine a trainee's progression status and their completion of the Training Program.</p> |
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- 9.5 The Training Provider has a clear process to identify, manage and support a trainee where there is a concern about their performance, progression, professionalism, or conduct.
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- 9.6 A trainee receives constructive informal and formal feedback on their performance and is supported to act on it.
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- 9.7 A supervisor providing feedback or performing an assessment has expertise in delivering feedback, the area being assessed and the assessment tool, acts honestly, and can justify their statements and decision.
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Appendix F4: Advanced Training Program Requirements

Details of all Advanced Physician Training criteria can be found on the RACP website under Advanced Training.¹⁰⁷ Separate links to each of the Standards are provided below.

Table 9 Links to RACP Standards for the Accreditation of Advanced Training Settings

Speciality	Link to Accreditation Standards criteria
Addiction Medicine	Accreditation criteria
Adolescent and Young Adult Medicine	Accreditation criteria
Cardiology	Accreditation criteria
Clinical Genetics	Accreditation criteria
Clinical Pharmacology	Accreditation criteria
Community Child Health	Accreditation criteria
Dermatology	Accreditation criteria – Domain 1 Accreditation criteria – Domain 2
Endocrinology	Accreditation criteria
Gastroenterology	Accreditation criteria
General and Acute Care Medicine	Accreditation criteria
General Paediatrics	Accreditation criteria (Australia)
Geriatric Medicine	Accreditation criteria
Haematology	Accreditation criteria
Immunology and Allergy	Accreditation criteria
Infectious Diseases	Accreditation criteria
Medical Oncology	Accreditation criteria (Australia)
Neonatal and Perinatal Medicine	Accreditation criteria
Nephrology	Accreditation criteria
Neurology (The Australian and New Zealand Association of Neurologists undertakes site accreditation for Neurology positions.)	Accreditation criteria
Nuclear Medicine (The Australian Association of Nuclear Medicine Specialists undertakes site accreditation for Nuclear Medicine posts in Nuclear Medicine.)	Accreditation criteria

¹⁰⁷ <https://www.racp.edu.au/about/accreditation/apply>

Speciality	Link to Accreditation Standards criteria
Paediatric Emergency Medicine (ACEM undertakes Site Accreditation for Paediatric Emergency Medicine.)	Accreditation criteria
Occupational and Environmental Medicine	Accreditation assessment form
Palliative Medicine	Accreditation criteria (Adult) Accreditation criteria (Paediatrics)
Public Health Medicine	Accreditation standards
Rehabilitation Medicine	Accreditation criteria
Respiratory and Sleep Medicine	Accreditation criteria (adult respiratory medicine); Accreditation criteria (adult sleep medicine)
Rheumatology	Accreditation criteria
Sexual Health Medicine	Accreditation criteria



Appendix G: Royal Australasian College of Surgeons (RACS)

The Royal Australasian College of Surgeons (RACS) is the leading body for surgical education in Australia and New Zealand. RACS is a not-for-profit organisation that supports the ongoing development, maintenance of expertise and lifelong learning that accompanies surgical practice. Representing its membership including 7,000 surgeons and 1,300 surgical trainees and International Medical Graduates, RACS also supports healthcare and surgical education in the Asia Pacific region.

College Governance

The recently released RACS Strategic Plan 2022-2024 has four priorities to ensure quality outcomes for the surgical profession and 'improve access, equity, quality and delivery of surgical care that meets the needs of diverse communities'¹⁰⁸:

- Leading a Sustainable Future for Surgery
- Serving All Communities Equitably
- Enhancing Member Value
- Operational Excellence

A part of 'Building a Culture of Respect' will include 'promoting rural equity, strengthening the workforce, and reducing maldistribution'.

'Leading a Sustainable Future for Surgery' includes a focus on leading 'new resilient and sustainable models of education, training, examination and research' working with 'the AMC / MCNZ and partners to innovate models for education, examination and research'.

Under 'Serving All Communities Equitably' RACS aims to 'champion Aboriginal, Torres Strait Islander and Maori health outcomes, delivery and education' and 'reduce rural health inequity through increasing surgical workforce and reducing workforce maldistribution' targeting 'increasing the proportion of Fellows working in rural and regional locations.' This will be achieved through strategic projects with partner organisations, 'increasing the number of Aboriginal, Torres Strait Islander and Maori doctors in training' and 'increasing the proportion of Fellows working in rural and regional locations.'

Operational Excellence will 'modernise organisational structures, processes, reporting, benchmarking, decision-making and people capability' to enable increased agility, flexibility, resilience, responsiveness and sustainability across the organisation.

The Business Plan 2022 informs the annual budget process and specifically identified key business priorities for the 2022 year.

108 RACS Strategic Plan 2022-2024, https://www.surgeons.org/-/media/Project/RACS/surgeons-org/files/2022-03-24_RACS-Strategic_Plan-2022-2024.pdf?rev=f77824aaf0ac444d8d87785ba7e711be&hash=F1ADAE69313E20CAD263537BC89EF281

Under the priorities identified in the Strategic Plan 2022–2024, the Business Plan 2022 will focus on five Flagship Programs:

1. Building Respect, Improving Patient Safety: From Awareness to Action
2. Implementing the Rural Health Equity Strategy
3. Championing Aboriginal, Torres Strait Islander, Maori health
4. Advocating for workforce and health care sustainability
5. Improving RACS services.

As part of the implementation of the Rural Health Equity Strategic Action Plan¹⁰⁹, released in December 2020, RACS will develop an ‘evidence resource for assessing rural hospitals in training post accreditation applications’, focus on funding and filling STP and Tasmanian training posts under the STP and establish a Northern Territory Pilot Program.¹¹⁰

The Rural Health Equity Strategic Action Plan is championed by the RACS Rural Surgery Section and RACS Council.

‘The RACS Rural Strategy aims to improve health equity for remote, rural and regional/provincial people in Australia and New Zealand.’ The strategy aims to:

1. increase the rural surgical workforce and reduce workforce maldistribution, through the Represent, Select, Train and Retain for Rural strategies.
2. build sustainable surgical services in Australia and New Zealand, through the Collaborate for Rural strategy.

1 Represent for Rural

To attain rural health equity, these actions emphasise the importance of rural representation in the decision making process. It will underpin the four rural strategies which focus on selecting, training, retaining, and collaborating for rural communities.

2 Select for Rural

These actions have the longest timeframe to yield results, are the least complex to address and require the least input of resources to achieve.

3 Train for Rural

These actions address Australian Medical Council and Medical Council of New Zealand standards of training for excellence and community need. There is flexibility in the local delivery of these actions based on the ratios of surgical specialist-to-population in Australia and New Zealand, and the number of surgeons in each specialty in various geographical settings.

109 RACS Rural Health Equity Strategic Action Plan, <https://www.surgeons.org/-/media/Project/RACS/surgeons-org/files/interest-groups-sections/Rural-Surgery/RPT-Rural-Health-Equity-Public-FINAL..pdf?rev=1709767dffbd48cda7dbfa3c053c6b58&hash=717809CD51D32CE7F4C927E883515ECE>

110 RACS Business Plan 2022, https://www.surgeons.org/-/media/Project/RACS/surgeons-org/files/2022-03-30_BusinessPlan-2022-Final-3..pdf?rev=4a297f0261b54c03af32ed47cb8556fa&hash=95A464509514C4D4C735A8E360C8A815



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The actions will foster a skilled, broad scope of practice surgical workforce who can provide care to rural and remote areas of Australia and New Zealand and are capable of deployment for regional and global humanitarian work.

4 Retain for Rural

These actions involve the retention of individuals (FRACS and SIMGs) and of whole surgical teams and services.

5 Collaborate for Rural

These actions focus on providing care centred around patient and place, whereby access to safe surgery is delivered as close to home as possible.

Each priority area has a list of actions and deliverables to achieve strategic outcomes for rural health equity.

The RACS Rural Surgery Section is:

*'Dedicated to serving the interests of surgeons who practise outside the metropolitan areas of Australia and New Zealand. Its aim is to assist in the provision of surgical care of the highest standard to the people of regional, rural and remote Australia and New Zealand. Membership of the Rural Surgery Section is open to all Fellows with a stake or interest in this area.'*¹¹¹

Education Board

The Education Board is the senior board responsible for overseeing RACS' education policy, maintaining standards of surgical education, training and assessment standards, and approving doctors eligible for admission to Fellowship. The authority of the Education Board to develop, regulate and approve all educational activities is delegated by Council. The Education Board comprises various committees.

These include:

- Board of Surgical Education and Training (BSET)
- Board of Cardiothoracic Surgery
- Australian Board in General Surgery
- New Zealand Board in General Surgery
- Board of Neurosurgery
- New Zealand Board of Orthopaedic Surgery
- Board of Otolaryngology Head and Neck Surgery
- Board of Paediatric Surgery
- Australian Board of Plastic and Reconstructive Surgery
- New Zealand Board of Plastic and Reconstructive Surgery
- Board of Urology
- Board of Vascular Surgery
- Court of Examiners
- Surgical Science Examination and Clinical Examination Committee
- Pre-vocational and Skills Education Committee
- International Medical Graduates (IMG) Committee
- RACS Trainees' Association
- Post Fellowship Education and Training Committee.

¹¹¹ <https://www.surgeons.org/resources/interest-groups-sections/rural-surgery>

For orthopaedic training in Australia, RACS has delegated the powers of a RACS Specialty Training Board to the Federal Training Committee of the Australian Orthopaedic Association.

Accreditation Governance

The BSET has a representatives from each Specialty Training Board in its membership.

The BSET Executive ratifies decisions by the Specialty Training Boards on accreditation, surgical supervisors and trainee status.

The RACS Censor in Chief can also review accreditation recommendations and decisions if there has been a history of concerns with a training post or health setting. A review with the RACS Censor in Chief would be with the Chair of BSET and the relevant Specialty Training Board Chair.

Specialty Training Boards each have an agreement with RACS to deliver and oversee specialty training in a semi-autonomous manner, under the governance of RACS, as the AMC accredited body for surgical specialty training.

Under the overarching *RACS Policy – Training Post Accreditation and Administration*,¹¹² Specialty Training Boards are responsible for regulating Surgical Education and Training (SET) training posts. They have the autonomy to develop their own accreditation process, assess and determine if training posts meet educational standards for training, within the policy framework.

RACS and the Specialty Training Boards collaboratively developed a set of 44 accreditation criteria. These were based around seven core educational, clinical and governance standards required to provide training in a range of clinical contexts. Following the recommendations from the RACS action plan on Building Respect, Improving Patient Safety, an eighth standard was introduced so that institutions must also satisfy criteria that they have built and maintained a culture of respect. The 44 accreditation criteria are used by the Specialty Training Boards and may be supplemented by specialty specific criteria. There are different accrediting arrangements for each of the nine surgical specialities, the smaller specialties have RACS undertake the administration of the accreditation process whereas larger specialties are supported by the Specialty Societies.

112 RACS Training Post Accreditation and Administration, ETA-SET-043, https://www.surgeons.org/-/media/Project/RACS/surgeons-org/files/policies/eta-education-and-training-administration/set-surgical-education-and-training/eta-set-043_training_post_accreditation_and_administration.pdf?rev=53e5b7d7ab874394a728c03b29daecdf&hash=ABD6D7353B81B1C991F929082031AD5D&msclkid=cab835afae4d11ec9d8fd2d478f462ef



Appendices

Table 10. Specialty and Accreditation Supported By:

Specialty	Accreditation Supported By
Cardiothoracic Surgery	RACS
Otolaryngology Head and Neck Surgery (Australia)	Australian Society of Otolaryngology Head and Neck Surgery (ASOHNS)
Otolaryngology Head and Neck Surgery (New Zealand)	RACS
Paediatric Surgery	RACS
Plastic and Reconstructive Surgery	Australian Society of Plastic Surgeons (ASPS)
General Surgery	General Surgeons Australia (GSA)
Neurosurgery	Neurosurgical Society of Australasia (NSA)
Orthopaedic Surgery	Australian Orthopaedics Association (AOA)
Urology	Urological Society of Australia and New Zealand
Vascular Surgery	Australian and New Zealand Society for Vascular Surgery

Accreditation teams for each surgical specialty undertake the accreditation assessments and make recommendations on accreditation outcomes to the Specialty Training Boards. Specialty Training Boards approve recommendation decisions and report to BSET.

Surgical Education and Training Program

The Surgical Education and Training Program (SET) involves progression of surgical competency through a number of workplace experiential training rotations, workplace assessments, training and skills acquisition programs and other assessments under a framework of nine competencies to become a competent surgical specialist.

Derived from the CanMEDS competency framework, the RACS competencies cover:

- Medical Expertise
- Judgement – Clinical Decision Making
- Technical Expertise
- Professionalism and Ethics
- Health Advocacy
- Communication
- Collaboration and Teamwork
- Management and Leadership
- Education and Teaching
- Cultural Competence and Safety.

The RACS Competency Standards for Training includes five stages of progressive development in competency: pre-vocational, novice, intermediate, competent and proficient.

Each of the surgical specialties has developed a SET program using the RACS Competency Standards for Training.

Accreditation Framework

Accreditation Process

The accreditation of surgical training posts is the responsibility of each Specialty Training Board. Apart from the small surgical specialties of Cardiothoracic Surgery, Otolaryngology Head and Neck Surgery (New Zealand) and Paediatric Surgery that have support provided through the RACS office, the administration of the accreditation process for all other surgical specialties is provided by Specialty Societies.

While the accreditation process varies between Specialty Training Boards, each will generally follow a common framework.

New accreditation application submission timelines vary per specialty and are always initiated by a health service. Applications must be submitted for consideration by a set time to enable the specialties to assess and confirm the number of accredited posts ahead of the announcement of the new trainees commencing in the SET program and allocation to training posts. For most specialties (with the exception of General Surgery), allocation to training posts occurs between June and July for commencement at the beginning of the next academic year, usually 1 February. For General Surgery Australia, selection occurs during this time period, and allocation to training posts occurs later in the year.

Re-accreditation occurs every five years, unless otherwise specified. The process for re-accreditation will commence in the year prior to the expiry of accreditation. Training sites are notified by the specialty training boards of when re-accreditation will occur and any additional requirements.

All applications for new training posts and re-accreditation reviews of accredited training posts must be accompanied by specific documentation and data to validate and support the accreditation assessment. This may include case data to indicate case mix and case load, rosters, medical workforce numbers and composition in the unit, logbook data (up to two years of data), de-identified trainee feedback on the training post and health setting being accredited, previous accreditation reports, trainee evaluations, workplace assessments, education schedule and any other additional information relevant to accreditation.

Training posts must consider the governance of the health service in assessing whether they can demonstrate their ability to meet RACS accreditation standards and criteria and be able to demonstrate a culture of respect for both patients and staff. The hospital needs to demonstrate an open and transparent complaint management process and should be willing to engage with RACS about the complaints of unacceptable behaviours that impact the quality of training. Posts should also consider the educational facilities and systems, including computer facilities, IT support and access to study areas. The capacity to train surgeons, the quality of education, training and learning available, such as the schedule of learning experiences and opportunities for research and scholarly activity are also important requirements for accreditation.

Complete applications will undergo a desktop review by an accreditation team or panel prior to the scheduling of a site visit assessment. All applications for new training posts will have a physical site visit (or inspection), Specialty Training Boards will make a determination on re-accreditation reviews as to whether the training site requires a site visit or a review via web conference. In some cases, a paper based or logbook only review may be sufficient for re-accreditation.



Appendices

Accreditation Assessment Teams

Accreditation teams (or panels) who undertake site visits may consist of:

- Two Fellows of RACS (FRACS) (minimum) – who are specialty specific i.e. Orthopaedic Surgeons for Orthopaedic Surgery training posts. FRACS must have experience in supervision, education and training for the specialty they are assessing, one FRACS may be a member of the Specialty Training Board accreditation committee and may Chair the meeting.
- Jurisdictional Representative – a jurisdictional representative will be invited to participate on the panel for the jurisdiction under assessment i.e. a jurisdictional representative from the Victorian Department of Health and Human Services for a training post being assessed in Victoria.
- Trainee Representative – a current trainee in the specialty.

Careful consideration is given by each of the Specialty Training Boards in relation to any perceived, real or potential conflict of interest of accreditation teams to ensure the integrity of the accreditation process. As such, the construct of the team ensures that members of the accreditation teams are not employed by the health service, area, region or district. In addition, team members must not part of the same training network or program.

Where possible, consideration is given to including team members with specific knowledge, for example, a rural surgeon in relation to the assessment of a rural training post. This however, is more of an ad hoc consideration rather than a formal process.

All FRACS who participate in accreditation practices under any of the surgical specialties, do so on a pro-bono basis. FRACS will receive an allocation of CPD points towards annual professional development requirements for medical practitioner registration.

During the accreditation site visit (or web conference), there is some variation on who the accreditation teams interview at the health service, depending on the specialty. Commonly teams may interview:

- Hospital administration or executive such as the Chief Executive Officer, Director Medical Services, Chief Medical Officer
- Head of Department or Unit
- Supervisors of training
- Trainers
- Consultants
- Trainees – both accredited and unaccredited
- Personnel who work with the surgical specialty team such as nursing, administrative support for the specialty, etc.

Accreditation Outcomes and Status

Following the site visit, an accreditation report will be drafted by the accreditation team detailing the assessment outcome and if the training post has satisfactorily met the accreditation criteria and standards. The report will often indicate commendations and if there are any improvements required to meet accreditation standards and criteria. The draft report is provided to the health service for corrections of fact before the report is finalised and accreditation recommendations made to the relevant accreditation committee or Specialty Training Board for approval of the recommendation. Specialty Training Boards report accreditation outcomes to BSET at each BSET meeting, three times a year. Hospital accreditation is an agenda item at each BSET meeting.

Accreditation outcomes include accreditation status, may include the number of trainees and the maximum amount of time a trainee can spend at the training site. These outcomes are communicated to the health service administration and surgical department in writing. For those sites who achieve full accreditation, a RACS College Accreditation Certificate will be issued.

- **Accreditation:** A training post receives accreditation for a period of up to 5 years. The length of the accreditation differs from specialty to specialty and is dependent on a number of factors, including whether the post is new and being accredited for the first time.
- **Conditional Accreditation:** A training post does not meet all accreditation criteria and standards required for full accreditation and must progress towards meeting accreditation requirements identified by the Specialty Training Board, usually within a set period of time. Conditional accreditation may also require a follow up site visit by an accreditation team.
- **Accreditation Withdrawn:** A training post fails to meet accreditation criteria and standards. The deficiencies will be identified by the Specialty Training Board

Specialty Training Boards provide support to the training sites with accreditation deficiencies to progress towards satisfactorily meeting accreditation criteria and standards to regain full accreditation.

It is the responsibility of accredited training posts and sites to advise the relevant Specialty Training Board if changes occur onsite that may impact the educational quality and safety of surgical training posts.

When a health service is not satisfied with the outcome of an accreditation assessment, they may seek to appeal the decision through the RACS Appeal Committee. RACS has a policy for appeals in relation to college decisions.

The RACS Censor in Chief can also review accreditation of posts if there has been history of unacceptable behaviour (discrimination, bullying, sexual harassment, etc.) against a current member of a unit hosting an accredited training post. This review is held in conjunction with the Chair of BSET and relevant Specialty Board Chair.¹¹³

113 RACS, DOH Preliminary Online Survey Response – How Accreditation Practices Impact Building a Specialist Medical Workforce Consultation, 22 October 2019



Appendices

Accreditation Standards

The overarching accreditation standards for RACS are published on the RACS website and cover eight standards with 44 criteria, factors that are assessed by RACS and minimum requirements that health settings must meet for each of the criterion. Although health settings are required to meet each of the standards, there is flexibility around each criterion. The accreditation process is designed to be flexible in recognition that not every health setting will be able to provide the breadth of surgical experiences to fulfil all specialty training requirements. These may be achieved through a network or collaborative arrangement.

The overarching RACS Accreditation Standards and Criteria can be found at [Appendix G1](#) and links to each of the specialty specific Standards and Criteria is at [Appendix G2](#).

Specialty Training Boards Accreditation Standards and Practices

General Surgery

GSA manages the SET program for General Surgery in Australia and provides administrative and executive support to the Australian Board in General Surgery (BiGS).

The SET Program in General Surgery in Australia is structured over a four-year curriculum as follows:

- SET 2–5 satisfactory completion of 8 x six-month terms in posts accredited by BiGS beyond SET 2.

The BiGS is responsible for selection, the accreditation of hospital posts and the supervision and assessment of General Surgery trainees.

There are Training Committees of the specialty training board responsible for the management of trainees. These are:

- New South Wales / ACT
- Victoria/Tasmania
- Queensland
- Western Australia
- South Australia / Northern Territory

The *Hospital Accreditation and Trainee Feedback Regulations: For the Surgical Education and Training Program in General Surgery*¹¹⁴ is compliant with the RACS Accreditation and Administration Policy and the accreditation standards align with the RACS eight accreditation standards and 44 criteria.

The Australian BiGS added specialty specific criteria for general surgery in relation to the number of General Surgery Trainers, the impact of Fellows on the unit and in relation to SET trainees, caseload and case mix with minimum case numbers, outpatient clinics, night rosters and trauma post requirements.

There is a strict application deadline of 31 March prior to the year of commencement of training. All applications for accreditation must be made via the GSA Online Application.

114 <https://www.generalsurgeons.com.au/education-and-training/hospital-post-accreditation>

Accreditation assessments are conducted in two parts, a paper based review of an application for accreditation or re-accreditation submission is conducted by the appropriate Training Committee to determine if requirements are met for a physical inspection.

Accreditation inspections are organised by the specialty training board or appropriate Training Committee with an inspection panel consisting of a minimum of two but up to three Fellows, one trainee representative and a jurisdictional representative. Panel members must not be employed by the health service or health network being assessed. During the inspection interviews take place with hospital administrators (Director Medical Services, Chief Medical Officer, Hospital Medical Officer Manager, Director of Surgery and other Hospital Administrators), Surgical Supervisors, General Surgery Trainers and current onsite trainees. The panel conducts a visit of facilities associated with and required for general surgery specialty training. Previous accreditation reports, de-identified trainee survey feedback and logbook data will be considered as part of the assessment along with other required documentation.

Quinquennial inspections occur every five years and are conducted by the Board.

An accreditation report is drafted by the panel, reviewed by the hospital that was accredited for any corrections and finalised before being submitted to the Training Committee and Specialty Training Board.

All accreditation recommendations for training posts are made by panels to the relevant Training Committee for ratification. The Training Committee submits the accreditation recommendations to the Australian Board in General Surgery for approval. In the event of quinquennial inspections, the panels makes the accreditation recommendations to the Australian BiGS for approval. Accreditation decisions made by the Australian BiGS are reported to the next BSET meeting. A certificate of accreditation is provided to the accredited health setting following the BSET meeting.

Accreditation will be awarded at the level of SET2–SET5 indicating that a training post will be suitable for trainees at those levels. Training posts that are only suitable for a specific level will have this identified in the accreditation report and subsequent recommendation.

Each post will be identified as one of the following subspecialties:¹¹⁵

- Acute Surgical Unit
- Breast
- Breast and Endocrine
- Cardiothoracic
- Colorectal
- Endocrine
- General Surgery Trauma.
- Upper gastrointestinal (GI)
- Upper GI and HPB
- Urology
- Vascular
- Trauma
- Head and Neck
- Hepatobiliary (HPB)
- Oncology
- Paediatric
- Plastics
- Thoracic
- Transplant

Training post accreditation is based on a five year cycle however, training posts may be accredited for less than five years and for no less than 12 months.

¹¹⁵ <https://www.generalsurgeons.com.au/education-and-training/hospital-post-accreditation>



Neurosurgery

The administration and management of the SET program in neurosurgery is delegated to the NSA in accordance with a service agreement. The Board of Neurosurgery reports to the NSA and RACS on matters related to the SET program.

The SET program in neurosurgery is a competency based training program that can be completed in a minimum of five years, maximum of nine years. It comprises of three sequential levels, Basic Training, Intermediate Training and Advanced Training and all training must be in accredited training posts in appropriately designated levels. SET Program training posts are classified as General and Paediatric Posts. General Posts do not have a maximum training period (except for the maximum term for training being nine years), Paediatric Posts are for a maximum rotation of six months.

Basic Training is for a minimum of one year, maximum of two years and covers foundational skills and amongst other training requirement and assessments, must include:

- A minimum of 200 major neurosurgical procedures.
- Participation in a minimum of 80 major neurosurgical procedures for each six months.

Intermediate Training is for a minimum of three years, maximum of four years and amongst other training requirements and assessments, must include:

- A minimum of 800 major neurosurgical procedures.
- Participation in a minimum of 80 major neurosurgical procedures for each six months.

Advanced Training is for a minimum of one year, maximum of three years and amongst other training requirements and assessments, must include:

- A minimum of 200 major neurosurgical procedures during Advanced Training of which a minimum of 100 must be as primary surgeon.
- A minimum of 50 major paediatric neurosurgical cases which can include those completed during Basic Training and Intermediate Training.
- Participation in a minimum of 80 major neurosurgical procedures for each six months.

Trainees are allocated by the Specialty Training Board to all accredited training posts. Trainees are recommended to primary sites for employment, however, employers make employment decisions and may choose not to employ recommended trainees.

The Training Post Accreditation Regulations¹¹⁶ underpins the accreditation framework for the SET program in neurosurgery. These regulations are compliant with the RACS Accreditation and Administration Policy and the eight accreditation standards with 44 criteria. The criteria have been developed to meet specialty specific training requirements.

There is an application deadline of 1 March prior to the year of commencement of training for any new training post. Assessments are made throughout April, May and June. The process is finalised in June so that existing trainees can be allocated to posts which have been reaccredited for the following training year and new trainees can be selected to the available posts. There is flexibility provided the process can still be completed by June in the year prior to training commencement.¹¹⁷

116 Training Post Accreditation Regulations Surgical Education and Training in Neurosurgery, RACS and NSA, https://nsa.org.au/common/Uploaded%20files/SET/SET_Post_Regs.pdf

117 Neurosurgical Society of Australasia, submission to DOH Accreditation Project, 11 December 2019

Applications can be submitted by a single training unit (primary site) or multiple units in collaboration. Multiple units can be a combination of primary and secondary sites, but must always have a primary site included in the application. All units in a multiple unit application will be assessed, secondary sites are those that do not meet primary site accreditation criteria. Trainees are only allocated to primary sites. Where secondary sites are accredited in conjunction with one or more primary sites, trainees may spend no more than 25% of their time in the rotation at the secondary sites combined. For neurosurgery, the number of major neurosurgical procedures, as identified in the training post accreditation logbook, required to be performed annually in the sites are as follows, noting these are absolute and the minimum criteria for an application for accreditation:

- for one training post there must be 400 major cases of which a minimum of 300 must be in each primary site
- for two training posts there must be 600 major cases of which a minimum of 450 must be in each primary site
- for three training posts there must be 900 major cases of which a minimum of 675 must be in each primary site.

This assists in the alignment of the number of posts to the volume of services delivered.¹¹⁸

The Specialty Training Board chair will appoint an accreditation panel to assess accreditation applications. Panels consist of at least two neurosurgeons and one board member to review the application and determine if an inspection is required. If an inspection is required, a fee may be charged to cover direct costs of accreditation.

During the inspection interviews take place with senior hospital management, consultant surgeons, supervisors, current onsite accredited and unaccredited trainees and neurosurgical support services. The panel also conducts a visit of facilities required for neurosurgery specialty training.

Under 1.3.10 of the regulations, it is not necessary for all criterion under the eight standards to be met. It is up to the accreditation panel to determine if enough of the criteria are met to demonstrate compliance with the standard has been met.

An accreditation report is drafted by the accreditation panel, reviewed by the hospital that was accredited for any corrections and finalised. The accreditation panel has the delegated authority of the specialty training board to make a determination on the accreditation outcome.

If accreditation or re-accreditation is withdrawn, the training site will receive communication from the specialty training board in writing of the decision, the standards that have not been met and requirements to meet the standards. It is up to the training site to meet the accreditation requirements demonstrate how it satisfactorily meets the accreditation requirement when it re-applies for accreditation.

The Specialty Training Board will note the determination of the accreditation panel and the accreditation report at its next scheduled meeting. The Specialty Training Board will report accreditation outcomes to BSET at the next meeting.

Five year accreditation is awarded to sites who meet all standards and criteria. Shorter accreditation periods may be awarded to those sites that do not satisfy all criteria.

118 Neurosurgical Society of Australasia, submission to DOH Accreditation Project, 11 December 2019



Appendices

Orthopaedic Surgery

The Australian Orthopaedic Association (AOA) is the peak professional organisation for orthopaedic surgeons in Australia. The AOA Board is accountable for the administration and delivery of the AOA 21 Training Program in orthopaedic surgery under the auspice of RACS, under a service agreement. The service agreement clearly articulates the roles and responsibilities of the AOA and RACS in relation to specialty training. The AOA articulates the 'policies in principle' for the delivery of specialty training in orthopaedic surgery and the accreditation of hospitals and training posts in orthopaedic surgery.

The AOA 21 Training program in Orthopaedic Surgery is competency based, however there is a minimum duration of four years.

The accreditation standards are modelled off the RACS and Australian Health Ministers' Advisory Council (AHMAC) accreditation standards¹¹⁹ and consist of five accreditation standards and 46 criteria defining the requirements for the provision of specialty training in orthopaedic surgery. These are detailed in the *AOA 21: Accreditation Standards for Hospitals and Training Positions*.¹²⁰

Within these standards, there are 'mandatory' and 'desirable' criteria. For a training post to achieve full accreditation, they must meet all mandatory criteria. The desirable criteria provide training posts with the opportunity to progress towards meeting these criteria under an improvement plan.

The *AOA Accreditation Process*¹²¹ outlines the process, accreditation outcomes and governance arrangements for the AOA accreditation of training posts. In the governance structure, applications for accreditation must be submitted to the relevant Regional Committee who reviews the application and recommends to the AOA Accreditation Committee the suitability of the training post for the Regional Network. The Regional Committees are:

- Queensland
- Western Australia
- South Australian/Northern Territory
- Victoria/Tasmania
- New South Wales, Northside
- New South Wales, Southside
- New South Wales, Newcastle

The AOA Accreditation Committee consists of two representatives from each of the regions, a jurisdictional and trainee representative. The AOA Accreditation Committee determines if the accreditation assessment will be a review via web conference or a site visit and will establish an accreditation review team with thorough consideration of COI in the composition of the review team.

Accreditation review teams consist of two orthopaedic surgeons, one who sits on the Accreditation Committee and assumes the role of Chair, one trainee representative and one AOA staff member. An orthopaedic surgeon who wishes to become an AOA Accreditor must be a member of AOA, involved or previously involved in delivery of the AOA 21 Training Program, actively participate in CPD and be knowledgeable about the curriculum and training regulations. Formal accreditation review training is provided for accreditors.

119 AOA submission to DOH, 3 December 2019

120 AOA 21 Accreditation Standards for Hospitals and Training Positions, [https://aoa.org.au/docs/default-source/training-\(public\)/accreditation/aoa-accreditation-standards-for-hospitals-and-training-positions-nov-21.pdf?sfvrsn=1b8ed504_2](https://aoa.org.au/docs/default-source/training-(public)/accreditation/aoa-accreditation-standards-for-hospitals-and-training-positions-nov-21.pdf?sfvrsn=1b8ed504_2)

121 AOA Accreditation Process, [https://aoa.org.au/docs/default-source/training-\(public\)/accreditation/aoa-accreditation-process-jun-20-update-v2-2.pdf?sfvrsn=6c3bde04_2](https://aoa.org.au/docs/default-source/training-(public)/accreditation/aoa-accreditation-process-jun-20-update-v2-2.pdf?sfvrsn=6c3bde04_2)

During the site visit, the review team will interview the hospital administration (Chief Executive Officer and Director Medical Services), Head of Department, Director of Training, Trainee Supervisors and trainees in accredited positions. The review team may also meet with other personnel that work with trainees, including nursing staff. The review team may also conduct a visit of facilities associated with and required for orthopaedic training. Previous accreditation outcomes, trainee evaluations, de-identified 'end-of-term' trainee survey feedback, workplace assessments and eLogbook data will be considered as part of the assessment along with other required documentation.

The review team drafts a report following the completion of the review and provides it to the Accreditation Committee Chair or delegate for review to ensure the team's findings and comments are consistent with the accreditation standards. The draft report is provided to the hospital for corrections of fact and any amendments before the accreditation outcome is determined and finalised by the Accreditation Committee. The Accreditation Committee makes accreditation recommendations to the Federal Training Committee for ratification.

Accreditation outcomes include:

- **Provisional Accreditation:** Granted to a new training post that meets all standards and criteria. This is for 12 months from the time a trainee commences training, during which time an accreditation review will be conducted to assess if the training post continues to meet the accreditation standards and criteria. If so, the training post is granted full accreditation.
- **Full Accreditation:** A training post that has proven to be suitable for training and meets all the mandatory criteria of the accreditation standards.
- **Conditional Accreditation:** Applies when a training post with full accreditation no longer meets all the mandatory criteria in the accreditation standards. The training post will be provided with a period of up to 12 months to demonstrate progress towards remediating the non-compliance issues. A supplementary accreditation review will occur during this time to determine if the training post has satisfied the mandatory criteria to regain full accreditation or if accreditation is withdrawn.
- **Accreditation Withdrawn:** Accreditation is withdrawn from a training post when the site has failed to progress towards satisfying the mandatory criteria under conditional accreditation or if serious issues are raised and substantiated and there has not been progress towards meeting the standards.

Although full accreditation is for five years, each accredited training post must participate in annual monitoring by submitting a completed 'Annual Training Site Information Form' to the Regional Committee prior to 1 November. The Federal Training Committee regularly monitors trainee experience in training posts through the 'end-of-term' surveys, eLogbook's, assessment completion and any other training data.

There is an application deadline of 1 February prior to the year of commencement of training for any new training post.



Appendices

Plastic and Reconstructive Surgery

The Australian Society of Plastic Surgeons (ASPS) administers the five year SET program for plastic surgery on behalf of RACS. Plastic surgery trainees mainly undertake their training in public major teaching hospitals and some private hospitals across Australia.

Trainees begin training in SET1 and are expected to complete at least five and no more than nine years of Surgical Education and Training in Plastic and Reconstructive Surgery in Australia. Flexible training (not less than 0.5 FTE) is available from SET 2 onwards.

The accreditation of training posts incorporates all the eight accreditation standards and 44 criteria set by RACS as well as additional specialty specific criteria for plastic and reconstructive surgery.

The accreditation process follows the process identified by RACS with the Australian Board of Plastic and Reconstructive Surgery considering accreditation recommendations made by accreditation teams. The Board approves accreditation recommendations and reports accreditation outcomes to BSET.

Urology

The Urological Society of Australia and New Zealand (USANZ) administers the SET Program in Urology through the RACS. The Board of Urology is responsible for the accreditation of training posts across Australia and New Zealand ensuring that all training posts can provide adequate training opportunities, learning environments and comply with the minimum standards for the training of safe and competent urologists. The Surgical Education and Training in Urology (nSET1- nSET5/SET6) Training Post Accreditation Standards and Criteria aligns the accreditation standards for the urology SET program with the overarching eight accreditation standards of RACS. The criteria are adapted to be specific to urology and the requirements for specialty training.

The SET Program in Urology is structured over a five year sequential curriculum as follows:

- nSET 1 Foundations of Urology
- nSET 2–4 Advanced Urological Training
- nSET 5 Transition to Independent Practice.

The *Training Post Accreditation Regulations, Surgical Education and Training in Urology* identifies the parameters for assessment and accreditation of training posts for urology and complies with the RACS Accreditation and Administration Policy. A Training Post Accreditation Subcommittee assists the specialty training board in reviewing and assessing posts for accreditation.

Under 2.6 of the regulation, 'The Board recognises that a wide range of hospitals and health services can accommodate urological training and education. Some have major strengths, or unique training experiences, but may also have some minor accreditation deficiencies. The Board recognises that there is benefit in utilising posts in such hospitals for their positive attributes, and rotating a trainee through SET Urology posts with complementary attributes'.¹²²

122 Training Post Regulations, Surgical Education and Training in Urology, January 2019, <https://www.usanz.org.au/educate-train/training-post-accreditation>

To this end, the Specialty Training Board also recognises that not every hospital will be able to meet all accreditation criteria 'due to the diverse nature of training posts and accepts the benefit of this diversity as it broadens the training experience'¹²³ and as such, there have been criteria that have been identified as 'mandatory' requirements and 'expected' requirements for varying levels of compliance and flexibility. This flexibility is linked to the ability of the site to comply with the criteria to a justifiable degree.

Inspections panels are established with at least two urologists with experience in supervision and training, one of which must have experience in accreditation. Panellists must not be employed by the health setting being assessed. During the inspection the panel interviews hospital administration (Director Medical Services), Head of Unit, Supervisors, consultants, urology support service employees, IMGs, trainees and unaccredited trainees and conducts a visit of facilities associated with and required for urology training. De-identified trainee survey feedback, timetables and logbook data will be considered as part of the assessment in addition to other required documentation and information for the purpose of accreditation.

An accreditation report is drafted by the panel, reviewed by the hospital that was accredited for any corrections and finalised before being submitted to the specialty training board.

Training posts are re-accredited on a five year cycle.

All accreditation outcomes for training posts are reported to the Board of Urology for approval and reported by the Board of Urology to BSET.

Vascular Surgery

The Vascular SET Program and hospital accreditation is administered by The Australian and New Zealand Society for Vascular Surgery (ANZSVS) in accordance with a 'partnering agreement'.

The SET Program in Vascular Surgery is structured over a five year sequential curriculum of speciality Vascular Surgery accredited training in posts.

The Board of Vascular Surgery adheres to the RACS Hospital Accreditation criteria and also applies speciality specific criteria under the *Hospital Accreditation Regulation: For the Surgical Education and Training Program for Vascular Surgery*.¹²⁴ The specific criteria include supervision requirements, minimum caseload and case mix numbers including the percentage of cases per SET year that the trainee must be the primary operator.

There is a strict application deadline of 31 January prior to the year of commencement of training.

Inspection teams must consist of a minimum of two Board members who are not employed by the health service being inspected. During the inspection interviews take place with hospital administration (Director Medical or Surgical Services), Head of Unit, Surgical Supervisors, consultants and trainees and the inspection team conducts a visit of facilities associated with and required for vascular training. Trainee survey feedback and logbook data may be considered as part of the assessment.

123 Training Post Regulations, Surgical Education and Training in Urology, January 2019, <https://www.usanz.org.au/educate-train/training-post-accreditation>

124 Hospital Accreditation Regulations for the Surgical Education and Training Program in Vascular Surgery, <https://www.anzsvs.org.au/wp-content/uploads/2021/01/REG-2020-10-30-BoVS-Hosp-Accred-Regulations.pdf>



Appendices

An accreditation report is drafted by the inspection team, reviewed by the hospital that was accredited for any corrections and finalised before being submitted to the Specialty Training Board.

Training posts are re-accredited on a five year cycle.

All accreditation outcomes for training posts are reported to the full Board of Vascular Surgery for approval and reported by the Board of Vascular Surgery to BSET.

Cardiothoracic Surgery

Cardiothoracic Surgery is represented by the Australian and New Zealand Society of Cardiac and Thoracic Surgeons.

The SET Program in Cardiothoracic Surgery is structured over a six-year sequential curriculum as follows:

- SET 1 Satisfactory completion of 4x three-month terms
- SET 2–6 Five years of satisfactory operative experience in Cardiothoracic Surgery training.

Otolaryngology Head and Neck Surgery

Otolaryngology Head and Neck Surgery is represented by The Australian Society of Otolaryngology Head and Neck Surgery in Australia and The New Zealand Society of Otolaryngology Head and Neck Surgery in New Zealand.

The SET Program in Otolaryngology Head and Neck Surgery is conducted over an average of five years and includes compulsory six-month rotations in Paediatric and Head and Neck surgery.

The training program is competency based with trainees moving through Novice, Intermediate and Competent.

The accreditation of training posts incorporates all the eight accreditation standards and 44 criteria set by RACS as well as additional specialty specific criteria for Otolaryngology Head and Neck surgery.

The accreditation process follows the process identified by RACS with the Board of Otolaryngology Head and Neck Surgery considering accreditation recommendations made by accreditation teams. The Board approves accreditation recommendations and reports accreditation outcomes to BSET.

Paediatric Surgery

Paediatric Surgery is represented by the Australian and New Zealand Association of Paediatric Surgeons Inc.

The SET Program in Paediatric Surgery is structured over a seven year sequential curriculum.

- Early SET – 1–2 years during which Early SET requirements are achieved, including the Anatomy and Embryology examination. The first year of the program is structured as a provisional year with some additional assessments and specific supervision to ensure smooth transition into surgical training.
- Mid/Senior SET – Mid and Senior SET is considered to be complete when compulsory courses, assessments, examinations and competencies identified in the curriculum are achieved, usually over four years.

Due to the size of the specialty, the RACS oversees the accreditation of Cardiothoracic, Otolaryngology Head and Neck and Paediatric SET training posts.

Rotations

Rotations are determined by each Specialty Training Board. Rotations and allocations of trainees depends on the size and structure of the surgical specialty. For smaller specialties such as Neurosurgeons, the trainees are selected and appointed to positions on a bi-national (including New Zealand) basis. For larger surgical specialties, such as General Surgeons, Training Committees allocate trainees to rotations within a training network which may be jurisdictionally based or across two jurisdictions, such as NSW and ACT. Rotations will often be determined by the training requirements a trainee must achieve to progress in their training.

Employment remains the responsibility of the health service, area, region or district.

Supervisors and Trainers

Surgical supervisors ensure the quality of workplace training are maintained, undertake assessments and performance monitoring of trainees, provide support to surgical trainees and promote respect, improved patient safety and professional conduct.

'A Surgical Supervisor is the Fellow at an accredited training post appointed by the Specialty Training Board, and noted by the Board of SET, with direct responsibility for coordinating the education program and for undertaking formative and summative assessments which are used to determine progress in the SET program.'¹²⁵

Specialty Training Boards determine eligibility requirements and review for surgical supervisors which will include CPD compliance. Surgical supervisors have a maximum term of nine years, unless authorised by the Censor in Chief.

'Surgical Trainers are surgical consultants who are members of a unit that has been accredited by RACS as a surgical training post and who interact with trainees in the workplace and in other educational activities.'¹²⁶

In Orthopaedic surgery, the Director of Training is primarily responsible for training within each accredited training site. The Director of Training works with Trainee Supervisors, as well as with other surgeons and consultants within the training environment, to provide the best possible learning environment for the trainee. A Director of Training oversees no more than five trainees at the site.

The Surgical Supervisor designated responsibility for the day-to-day supervision and training of a trainee occupying an accredited training post. The Surgical Supervisor is expected to provide direction and feedback to the trainee on a regular basis. A Trainee Supervisor oversees no more than two trainees. The Surgical Supervisor works with surgeons and other colleagues within the surgical department to provide the best possible learning environment for the trainee, and reports on the trainee's performance to the Director of Training¹²⁷ (Orthopaedics) or the Training Committees.

125 RACS Surgical Supervisors, ETA-SET-013, https://www.surgeons.org/-/media/Project/RACS/surgeons-org/files/policies/eta-education-and-training-administration/set-surgical-education-and-training/eta-set-013_surgical_supervisors.pdf?rev=2322462a15a84535b6f7cec5864745b3&hash=69EB2046829E7E38DC9D68EBEFE0992F

126 RACS Surgical Trainers, ETA-SET-020, https://www.surgeons.org/-/media/Project/RACS/surgeons-org/files/policies/eta-education-and-training-administration/set-surgical-education-and-training/eta-set-020_surgical_trainers.pdf?rev=f3188eddd50f4ee2b88f7bf8886140d9&hash=4DD127C31D24287BD18FB4CCB099C875

127 RACS, DOH Preliminary Online Survey Response – How Accreditation Practices Impact Building a Non-GP Rural Specialist Medical Workforce Consultation, 22 October 2019



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It is mandatory for all supervisors and trainers to complete RACS Operating with Respect course and Foundation Skills for Surgical Educators course (or an equivalent). RACS offers other professional development programs to support supervisors in their roles.

Some Specialty Training Boards (e.g. Cardiothoracic Surgery) host supervisors meetings every few years to specifically discuss how they can better meet the needs of supervisors of training organise strategy days to discuss this. Specialty Training Boards continue to assure RACS that they will:

- Provide training to supervisors on how to give feedback.
- Provide training for supervisors on how to support the poorly performing trainee.
- Develop orientation/induction for newly appointed supervisors.

Accreditation Monitoring, Evaluation and Review

The monitoring of accredited training posts is the responsibility of the Specialty Training Boards. The Specialty Training Boards review training posts every five years for re-accreditation or sooner if the accreditation period is shorter or issues that may impact the accreditation of a training post have been raised. Conditional accreditation also assumes a level of monitoring by a Specialty Training Board during the period of conditional accreditation.

Through the RACS Trainee Association, an 'end-of-term' survey is sent to all trainees at the end of their six month rotation. A number of surgical specialties also conduct their own independent surveys. These surveys address various aspects of their specialty training experience, including education and training satisfaction, flexible training availability and acceptance, bullying and harassment and industrial relations issues and the trainee's experience in the accredited training post. The results of this survey have been aggregated over five years and provided in a consolidated report for all surgical specialties. De-identified, specialty specific reports are also provided to the Specialty Training Boards. Some Specialty Training Boards use this feedback as part of their accreditation assessment of an accredited training post undergoing re-accreditation. This information may also be used in the case of issues being raised about accredited training posts and/or sites.

RACS undertakes reviews of the accreditation framework as required. Drivers of review and/or change include changes in the SET Program(s), supervision arrangements and regulatory changes. RACS is currently undertaking a project to review the accreditation framework, the project is pulling together the Specialty Training Boards, to try and bring about some greater consistency and commonality in the way that standards are applied and collaboration.

Some Specialty Training Boards have expressed to RACS that they would like centralised assistance from RACS on generic criteria to improve administration processes associated with accreditation.

The NSA made a submission to RACS in 2019 in relation to streamlining accreditation practices and reducing the accreditation burden for RACS, specialties and health services.

In addition, RACS is currently reviewing its Training Competency Standards. RACS will transition to a ten competency model in the SET Program with the additional competency being Cultural competence and cultural safety.

Changes to better support trainees

RACS is committed to ensuring that all training posts operate within a culture of respect.

The Expert Advisory Group (EAG) was established in 2015 in response to reports of unacceptable behaviour in the training workplace culture to investigate discrimination, bullying and sexual harassment in surgery. The EAG consulted broadly with the surgical community and other interested groups by conducting a prevalence survey, focus groups and interviews. It released its report in September 2015 and RACS accepted all the recommendations made by the EAG. The *RACS 2015 Action Plan: Building Respect, Improving Patient Safety*,¹²⁸ published in November 2015, details how the EAG recommendations will be implemented. Specialty Society Presidents supported the findings of the EAG and the RACS Action Plan. Recognising those recommendations, the 2016 update of the standards and criteria includes a new standard to assess whether the institution seeking accreditation is committed to building and maintaining a culture of respect.

Changes to better support supervisors

The updated accreditation criteria now include the requirement for supervisors to have protected administrative time and support. This is to ensure that the surgical standards expected by the Australian and New Zealand public are maintained, surgical supervisors need to observe trainees, plan educational activities and provide guidance, oversight and counselling.

Accreditation Data Management

Accreditation data is collected by each of the surgical specialties through various methods. Some have developed software programs to capture this information with web-based platforms to facilitate the accreditation function. Others maintain paper-based records and spreadsheets using Microsoft Excel.

Currently there is limited capacity to monitor and report on accreditation issues, due to individual manual recording at the specialty level. From June 2019, RACS has commenced working on a consolidated approach and is currently undertaking a strategic project to upgrade and replacing ageing IT infrastructure and website platform, with Microsoft as the preferred supplier.

128 RACS Building Respect, Improving Patient Safety, RACS Action Plan on Discrimination, Bullying and Sexual Harassment in the Practice of Surgery, https://www.surgeons.org/-/media/Project/RACS/surgeons-org/files/reports-guidelines-publications/action-plans/racs-action-plan_bullying-harassment_f-low-res_final.pdf?rev=364e80a0b46a4db9837f117f548b1513&hash=92FF3C64E63038B4FAE77FE09D7DE020



Appendix G1: RACS Accreditation Standards

The below table outlines the overarching RACS Accreditation Standards and Criteria. Full details can be found on the RACS website.¹²⁹

RACS Overarching Accreditation Standards and Criteria

STANDARD 1

Building and maintaining a culture of respect for patients and staff

A hospital involved in surgical training must demonstrate and promote a culture of respect for patients and staff that improves patient safety.

Accreditation Criteria:

1. The hospital culture is of respect and professionalism.
2. Partnering to Promote Respect: MoU, statement or agreement about the need for 'Building Respect, Improving Patient Safety'.
3. Complaint Management Process

STANDARD 2

Education facilities and systems required

All trainees must have access to the appropriate education facilities and systems required to undertake training.

Accreditation Criteria:

4. Computer facilities with IT support.
5. Tutorial room available.
6. Access to private study area.
7. General educational activities within the hospital.

¹²⁹ Accreditation of Hospitals and Posts for Surgical Education and Training, Process and Criteria for Accreditation, <https://www.surgeons.org/-/media/Project/RACS/surgeons-org/files/training-post-accreditation/accreditation-of-hospitals-and-posts-for-surgical-education-and-training.pdf>

STANDARD 3**Quality of education, training and learning**

Trainees will have opportunities to participate in a range of desirable activities, which include a focus on their educational requirements.

Accreditation Criteria:

8. Coordinated schedule of learning experiences for each trainee.
9. Access to simulated learning environment.
10. Access to external educational activities for trainees.
11. Opportunities for research, inquiry and scholarly activity.
12. Supervised experience in patient resuscitation.
13. Supervised experience in an ED.
14. Supervised Experience in ICU.

STANDARD 4**Surgical supervisors and staff**

Program managed by appropriate and accessible supervisor supported by the institution and committed surgeons, delivering regular education, training and feedback.

Accreditation Criteria:

15. Designated supervisor of surgical training.
16. Supervisor's role / responsibilities.
17. Credentialed specialist surgical staff willing to carry out surgical training.
18. Surgeons committed to training program.
19. Regular supervision, workplace-based assessment and feedback to trainees.
20. Hospital recognition and support for surgeons involved in education and training.
21. Hospital response to feedback conveyed by RACS on behalf of trainees.

STANDARD 5**Support services and flexibility for trainees**

Hospitals and their networks are committed to the education, training, learning and wellbeing of trainees who acknowledge their professional responsibilities.

Accreditation Criteria:

22. Hospital support for trainees.
23. Trainee's professional responsibilities – Duty of Care.
24. Flexible Training Options are available for Trainees.

STANDARD 6**Clinical load and theatre sessions**

Trainees must have access to a range and volume of clinical and operative experience which will enable them to acquire the competencies required to be a surgeon.

Accreditation Criteria:

25. Supervised consultative ambulatory clinics.
26. Beds available for relevant specialty.
27. Consultant led ward rounds with educational as well as clinical goals.
28. Caseload and casemix.
29. Operative experience for trainees.
30. Experience in perioperative care.
31. Involvement in acute/emergency care of surgical patients.



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STANDARD 7

Equipment and clinical support services

A hospital must have the facilities, equipment and clinical support services required to manage surgical cases in a particular specialty.

Accreditation Criteria:

- 32. Facilities and equipment available to carry out diagnostic and therapeutic surgical procedures.
- 33. Imaging – suitable diagnostic and intervention services.
- 34. Diagnostic laboratory services.
- 35. Theatre equipment.
- 36. Support/ancillary services.

STANDARD 8

Clinical governance, quality and safety

A hospital involved in surgical training must be fully accredited and have the governance structure to deliver and monitor safe surgical practices.

Accreditation Criteria:

- 37. Hospital accreditation status.
- 38. Risk management processes with patient safety and quality committee reporting to Quality Assurance Board.
- 39. Head of Surgical Department and government role.
- 40. Hospital Credentialing or Privileging Committee.
- 41. Morbidity and mortality and audit activities constituting peer review.
- 42. Higher level hospital systems reviews.
- 43. Experience available to trainees in Root Cause Analysis.
- 44. Occupational safety.

Appendix G2: RACS Links to Training Boards Accreditation Standards and Criteria

In addition to the overarching standards at Appendix G1, links to specialty specific criteria are provided in the below table, where available.

Table 10 RACS Links to Training Boards Accreditation Standards and Criteria

Specialty	Link to Accrediting Body Standards
Cardiothoracic Surgery	RACS
Otolaryngology Head and Neck Surgery	Australian Society of Otolaryngology Head and Neck Surgery (ASOHNS) (not available)
Paediatric Surgery	RACS
Plastic and Reconstructive Surgery	Australian Society of Plastic Surgeons (ASPS) (not available)
General Surgery	General Surgeons Australia (GSA)
Neurosurgery	Neurosurgical Society of Australasia (NSA)
Orthopaedic Surgery	Australian Orthopaedics Association (AOA)
Urology	Urological Society of Australia and New Zealand
Vascular Surgery	Australian and New Zealand Society for Vascular Surgery



Appendix H: Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG)

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) is a not-for-profit organisation dedicated to the establishment of high standards of practice in obstetrics and gynaecology and women's health. RANZCOG trains and accredits doctors throughout Australia and New Zealand in the specialties of obstetrics and gynaecology so that they are capable of providing the highest standards of healthcare. RANZCOG also supports research into women's health and acts as an advocate for women's healthcare by forging productive relationships with individuals, the community and professional organisations, both locally and internationally.¹³⁰

RANZCOG advocates on behalf of specialists, GP obstetricians and alongside midwives recognising that the speciality delivers care in a multi-disciplinary and multi-levelled model of care.

RANZCOG membership consists of Fellows, Members, Diplomates and Honorary Fellows. RANZCOG's annual report 2018–19 reports having 6,420 Members, (excluding trainees), 2350 Fellows and 720 Fellow of the RANZCOG (FRANZCOG) trainees. In the 2018–19 financial year, 135 trainees became Fellows. Greater than 75% of new Fellows are female.¹³¹

RANZCOG recognises regional FRANZCOG working in any rural and/or remote area classification RA2–5.¹³²

RANZCOG has five subspecialty areas, with training available post-Fellowship:

- Gynaecological Oncology
- Reproductive Endocrinology & Infertility
- Maternal Fetal Medicine
- Obstetric and Gynaecological Ultrasound
- Urogynaecology.

In November 2019, the AMC granted an extension of the accreditation of RANZCOG by four years to 31 March 2024. In February 2020, the MCNZ extended the RANZCOG's accreditation for the remaining balance of its accreditation period (until 31 March 2024) in line with the AMC.¹³³

130 <https://ranzcof.edu.au/our-college/>

131 RANZCOG Annual Report 2018-2019, https://ranzcof.edu.au/RANZCOG_SITE/media/RANZCOG-MEDIA/Governance/Annual%20Reports/Annual-Report-2019.pdf

132 Australian Standard Geographical Classification-Remoteness Area (ASGC-RA) devised by the Australian Bureau of Statistics.

133 <https://ranzcof.edu.au/news/amc-and-mcnz-extend-ranzcof%E2%80%99s-accreditation>

College Governance

RANZCOG is governed by a nine-member Board who are the directors of RANZCOG. The Board manages the financial, legal and business operations of the organisation and is supported in its activities by the Council and a range of committees.¹³⁴

The Council has general oversight of the policy and strategic planning and direction for the College and meets three times a year. Councillors serve a three year term. The current Council commenced in 2021. The Council has 35 members and includes the current Board and 22 councillors who are state/territory representatives with two councillors designated as regional, the immediate Past President, Chair Diplomates Committee, Chair Trainee's Committee and one councillor who is a non-voting community representative.¹³⁵

Strategic Plan 2022–2024

The RANZCOG's Strategic Plan 2022–2024 priorities are:

- Education and Training
- Member Engagement
- People and Wellbeing
- Sustainable Organisation
- Stakeholder Engagement
- Community, Equity and Advocacy

As the top priority, Education and Training key objectives include:

- 'Ensure alignment of the College's education and training with the Australian Medical Council (AMC) and Medical Council of New Zealand (MCNZ) standards
- Finalise and implement a renewed curriculum for each of the College's training programs in line with the CanMEDS Framework to provide contemporary medical education
- Implement new advanced training modules to expand the scope of advanced training to better suit the needs of our trainees and the community
- Improve our trainees' learning experiences through better scope and monitoring of accreditation standards across all programs
- Improve the quality, accessibility and delivery of assessments including workplace-based assessments, and explore innovative, cost-effective methods for exam delivery.¹³⁶

Under Sustainable Organisation, RANZCOG will focus on several objectives to develop sustainability in operations, initiatives and practices including 'contribute towards a sustainable and diverse O&G workforce, that can meet future women's health needs'.¹³⁶

134 <https://ranzcoг.edu.au/our-college/governance/board>

135 <https://ranzcoг.edu.au/our-college/governance/council-committees>

136 RANZCOG Strategic Plan 2022–2024, https://ranzcoг.edu.au/RANZCOG_SITE/media/RANZCOG-MEDIA/Governance/RANZCOG-Strategic-Plan-2022-2024.pdf



Accreditation Governance

The Australian and New Zealand Training Accreditation Committee (TAC) is responsible for:

- Formulating and review of the processes for accreditation and reaccreditation of the training programs leading towards the attainment of Fellowship of RANZCOG (FRANZCOG).
- Approval of hospitals and training posts suitable for FRANZCOG training and the development of training programs.
- Consideration and assessment of individual trainee programs leading towards FRANZCOG.
- Consideration of applications for elevation to FRANZCOG.
- Coordination of the development and maintenance of the training requirements associated with FRANZCOG.
- Coordination of the Integrated Training Program (ITP) hospital accreditation and re-accreditation process, including site visits to hospitals.

There are three RANZCOG council weeks per year, the TAC meets face to face with all regional chairs in attendance ahead of the three council weeks. RANZCOG is aiming to include more strategic accreditation discussions on the agenda. In terms of representatives on the TAC, RANZCOG ensures regional representation with the inclusion of a regional FRANZCOG. The TAC is supported by the Regional Training Accreditation Committees and two college staff.

Once an accreditation assessment and report is finalised, the TAC will make an accreditation recommendation to the RANZCOG Board for approval.

RANZCOG Specialty Training Program

The FRANZCOG Training Program is a six-year (276 weeks) structured post-graduate program culminating in Fellowship of the RANZCOG. It comprises:

- A four-year (184 weeks) Core Training Program.
- A two-year (92 weeks) Advanced Training Program.

The Core Training Program (years 1–4) is primarily conducted in major teaching hospitals, outer suburban/peripheral, rural/provincial hospitals and other expanded setting sites including private settings that have been accredited for such training by RANZCOG across Australia and New Zealand.

A combination of these different training sites forms a consortium, each known as an ITP. Trainees receive a significant proportion of their Core Training at a single home/base hospital and rotate to other hospitals in the ITP. An ITP would normally comprise at least two sites and will include at least one tertiary hospital and one rural hospital. Collectively, the participating hospitals must be able to provide the range of training experiences stipulated in the training and assessment requirements over the four years of the Core Training Program.

It is recognised that not all individual training sites within an ITP can provide the depth and breadth of specialist training necessary to fulfil all of the requirements of the FRANZCOG Training Program. Collaboration and flexibility is required within an ITP to ensure trainees have the opportunity to meet all requirements across the four years of their training.

Advanced Training requirements will vary for every trainee with learning plans developed to focus on developing expertise, competence, research and professional skills. Trainees are expected to develop a higher level of professional maturity and professionalism during this period. Advanced training includes six-month training in general obstetrics and six months training in general gynaecology.

Advanced training must be completed in a maximum of three years. Advanced training under minimal supervision arrangements will be considered, including the possibility of time without onsite supervision.

The Regional and New Zealand TACs are responsible for the oversight of Core and Advanced training in their state or region. The TAC also review applications for prospective approval of training submitted by FRANZCOG trainees in the relevant state or region. They are further responsible for reviewing trainees' online Six-monthly Summative Assessment Reports assessed as Other than Satisfactory, approving trainee logbooks and the appointments of Program Coordinators and Training Supervisors.

The Chairs of these committees are also responsible for reviewing and approving the online Three-monthly Formative Appraisal and Six-monthly Summative Assessment reports of trainees in the relevant region.¹³⁷

The eligibility of rural training posts is determined by the relevant state and territory or New Zealand TAC.

Supervisors

A Training Supervisor for the FRANZCOG Training Program (Core/Advanced) must be a FRANZCOG and employed at an accredited training site. The FRANZCOG may be a full-time or part-time staff specialist or, where appropriate, a VMO and formally approved by the relevant Regional TAC. The Training Supervisor is responsible for the overall supervision and mentoring of the Core/Advanced trainee. All trainees must have a designated Training Supervisor.¹³⁸

Core, Advanced and Subspecialty Training Supervisors are required to attend a RANZCOG Training Supervisor workshop every three years of their appointment.

There is currently a strong link between accreditation processes and supervisor training and RANZCOG has recognised that it is time to deliver educator/supervisor training pathway training independently to the accreditation process.

¹³⁷ FRANZCOG Training Handbook, 2013, <https://ranzocg.edu.au/training/specialist-training/curriculum-handbook>

¹³⁸ <https://ranzocg.edu.au/training/specialist-training/supervisors-coordinators>



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RANZCOG Integrated Training Program Coordinator

The ITP Coordinator is responsible for the coordination of the relevant ITP across participating hospitals, in close consultation with the relevant regional TAC in order to:

- Contribute to the quality of teaching and learning, and ensure effective monitoring/assessment of trainees' performance and progress to achieve the learning outcome as defined in the FRANZCOG Curriculum.
- Promote the clinical, educational and personal development of the trainees through appropriate encouragement, guidance and support.
- Facilitate communication on training/assessment/rotation issues between participating sites and between those sites and the relevant regional TAC.

Contribute to the maintenance of a safe and supportive training environment for trainees. The desired outcome for their role is to ensure the combined hospitals in an ITP provide trainees with appropriate clinical experience and supervision to meet the requirements of the Core Training component of the FRANZCOG Curriculum.¹³⁹

Six-monthly Summative Assessment

All consultants and senior registrars (in the case of junior registrars) who supervise a trainee are asked to contribute to the trainees' Six-monthly Summative Assessment across the three domains of clinical expertise, academic abilities and professional qualities.

Another responsibility of the Training Supervisor is in-hospital credentialing in collaboration with consultants and senior registrars. In-hospital credentialing is to ensure the attainment of clinical competency by trainees at the appropriate level, and to ensure that they are provided with the necessary level of consultant support.

Rotations

The rotations are determined by RANZCOG via jurisdictional committees.¹⁴⁰ Where possible, trainees are advised at least 12 months in advance of their rotations throughout the four years of Core Training, including their rural rotation. It is expected that trainees follow their allocated rotations. RANZCOG advises that the length of rotational terms is not built in to accreditation recommendations, rotational terms are determined by the ITP Coordinator.

139 FRANZCOG ITP Coordinator Position Description, 2017, https://ranzco.edu.au/RANZCOG_SITE/media/RANZCOG-MEDIA/Training%20and%20Assessment/Specialist%20Training/Coordinators%20and%20Supervisors/ITP-Coordinators-PD_2017.pdf

140 RANZCOG, DOH Preliminary Online Survey Response – How Accreditation Practices Impact Building a Specialist Medical Workforce Consultation, October 2019

Rural Training

All trainees entering the Core Training Program must complete at least one prospectively approved and satisfactorily assessed period of at least 23 weeks FTE in a rural location.

The compulsory rural rotation provides all trainees with an understanding of the issues facing a rural patient and a rural specialist, such as:

- The strategies that are necessary when practising in the absence of proximity to subspecialists and tertiary facilities.
- The importance to rural patients of geographical proximity to health services.
- The challenges of patient transfer issues when the need arises.

The rural rotation also provides greater opportunities for gynaecological surgical training that is more readily available in a regional centre. The rural rotation provides:

- A greater volume and case-mix of gynaecological surgery (approximately 80% more than the average tertiary rotation and 40% more than the average metropolitan hospital rotation).
- An opportunity to enhance confidence and competence in core operative skills and gain increasing independence in skills needed for Advanced training and specialist practice;
- The opportunity to be involved in outpatient and outreach clinics that may not normally be available in metropolitan centres.
- Exposure to different models of patient and follow-up care.

Trainees are advised by the ITP Coordinator/Training Supervisor of planned rotations for the four-year program, at the commencement of Year 1. Approval for training in a rural rotation is based on the merits of the rural training post. Flexibility regarding the model for training supervision is considered for rural training posts.

Accreditation Framework

RANZCOG accredits hospitals and training posts for the delivery of the Core components of the FRANZCOG Training Program for an accreditation cycle of four years. For the last two years of training, Advanced Training, the training is accredited. A trainee must submit their proposed training which could cover a range of settings including private, rural or academic and is not always hospital based or public metropolitan hospital based. The Chair of TA in the relevant region or New Zealand, assesses and approves the training plan.

Accreditation ensures that there are defined minimum acceptable specialty training standards. Training sites must be able to provide RANZCOG trainees with a range of clinical and education experiences defined in the FRANZCOG Curriculum to develop their skills and meet training program requirements.

RANZCOG articulates in the Accreditation Standards and Guidelines for Hospitals in the FRANZCOG Training Program that the accreditation standards assist training sites in identifying factors that can adversely impact capacity to deliver effective and supported training to FRANZCOG trainees. The standards allow RANZCOG to work with training sites and their relevant Regional TAC to formulate strategies to maximise training opportunities, and ensure efficient and safe service delivery provision by FRANZCOG trainees.



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The accreditation process is supported and centralised at the central RANZCOG office level rather than jurisdictionally through the Regional TAs. Community need is taken into consideration at a strategic development level rather than at the operation level.

RANZCOG have an underpinning set of principles to ensure the considered, balanced, and objective assessment of hospitals and health services against the accreditation standards and criteria.

Principles of RANZCOG Hospital Accreditation

In accrediting and reaccrediting FRANZCOG training hospitals, RANZCOG will:

1. Make balanced and objective assessments of the hospital's performance as a training site.
2. Base the accreditation process on clearly defined criteria and implement it in an open and equitable manner.
3. Have an ongoing process of review to ensure that recommended changes are implemented at each accredited training site and to ensure they are given adequate opportunity and support to enable them to implement recommendations effectively.
4. Regularly review the standards and processes of hospital accreditation and reaccreditation.

In addition, RANZCOG takes further measures to increase objectivity and consistency such as accreditation advisors at RANZCOG to review the accreditation reports submitted by different accreditation teams. There is calibration of accreditator assessment to ensure aligned and transparent decision making in accreditation. In future, RANZCOG aim to introduce a suite of set recommendations and conditions for accreditation teams to utilise in making accreditation assessments and decisions to increase consistency across the training system.

FRANZCOG Training Program Accreditation Standards

RANZCOG has six accreditation standards with criteria under each standard and minimum requirements for each criteria which are considered necessary for the provision of effective training and support for trainees in the FRANZCOG Training Program.

[Appendix H1](#) outlines the accreditation standards and criteria, further details on minimum requirements under each criteria can be found in the *Accreditation Standards and Guidelines for Hospitals in the FRANZCOG Training Program*.¹⁴¹

Accreditation Teams

Accreditation team composition considers practical first-hand experience of the FRANZCOG Training Program and comprises RANZCOG Fellow(s) from a region other than the one in which the site visit is being conducted who is the team leader, a member of the relevant Regional TAC, a senior RANZCOG staff member responsible for the administration of the accreditation process, RANZCOG trainee representative (from another region) and a representative from the relevant State or Territory department of health or equivalent where appropriate. While RANZCOG extends an invitation to the relevant health jurisdiction, participation is at their discretion.

141 FRANZCOG Accreditation Standards and Guidelines for Hospitals in the FRANZCOG Training Program, Process and Criteria, v1.7 November 2021, https://ranzcof.edu.au/RANZCOG_SITE/media/RANZCOG-MEDIA/Training%20and%20Assessment/Specialist%20Training/Hospitals/FranzCOG-Accreditation-Standards-and-Guidelines-for-Hospitals.pdf

Initial Accreditation of New Training Sites

Hospitals wishing to apply for accreditation as a training site must make an application to RANZCOG demonstrating the site's capacity to meet RANZCOG accreditation standards. Each application must be supported by the relevant Regional TAC.

Following a desktop review of the application, an initial site visit is conducted by an accreditation team. The team assesses the degree to which the health service meets the accreditation standards and criteria. The visit includes interviews with Obstetrics and Gynaecology (O&G) trainees, the Head of Department, consultants, senior midwifery and nursing staff, and hospital management. In addition, the team attends morning handover and tours the O&G Department's facilities.

A recommendation on the hospital's accreditation or otherwise is then considered at the next meeting of the RANZCOG TAC, with a recommendation to the RANZCOG Board as applicable including the duration of the initial period of accreditation if granted.

Twelve months after the first RANZCOG trainee commences training at the newly accredited site, a follow-up review visit is conducted. During this initial period of accreditation, the relevant Regional Training Accreditation Committee will monitor the training provided and provide advice to RANZCOG should an earlier review be considered necessary. If performance is satisfactory, ongoing accreditation will be granted for the remainder of the initial accreditation period subject to satisfactory progress reports. If performance is other than satisfactory, RANZCOG will determine whether to grant an extension or withdraw the initial period of accreditation.

The implementation of the recommendations of accreditation happens at the level of the Regional Training Accreditation Committees.

Application for Reaccreditation

Hospitals are normally reaccredited on a four-yearly cycle. Re-accreditation provides training sites with the opportunity to engage in improvement and development measures in the support and delivery of specialty training. RANZCOG supports training sites to make any improvements considered necessary, including determining with training site accreditation conditions and/or recommendations that are achievable within an appropriate timeframe. Where necessary, there is also support provided to the training site in relation to relevant health jurisdictions to address any specific accreditation conditions or recommendations.

A re-accreditation date is provided to hospitals two months prior to the expiry of the four year accreditation cycle. At this time, the hospital is notified of information and documentation required for the re-accreditation. Data from the O&G surgical logbooks from O&G has assisted RANZCOG to identify case and education opportunities for trainees at training sites and is used as a component of accreditation assessment. It enables RANZCOG to ensure sites are only accredited if they can provide appropriate training opportunities.

All current trainees and trainees from the previous six month rotation receive a questionnaire on their training experiences in accordance with each of the accreditation standards. This information in addition to previous accreditation history and procedural data is provided to the accreditation team ahead of the assessment.



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Accreditation Site Visit

The site visit usually takes a full day consisting of interviews with trainees in all year levels, Fellows and other relevant health professionals at the site, e.g. the Director(s)/Head(s) of O&G, ITP Coordinator (if applicable), Training Supervisors, staff specialists, consultants, senior nursing and midwifery staff, theatre managers, paediatrics and anaesthetists who have worked with the trainees, and hospital management.

The accreditation team will attend morning handover in the birthing suite, tour the O&G department, including birthing suite, theatre and clinics, conduct a review of the on-line resources offered by the hospital, visit the library, trainees' room, facilities and any accommodation provided for trainees if a rural hospital.

At the conclusion of the site visit, the accreditation team determines initial findings and the most appropriate reaccreditation rating. These initial findings, and the likely reaccreditation rating, are discussed with the Director(s)/Head(s) of O&G and hospital management before the team leaves the site.

RANZCOG prepares the reaccreditation report, which comprises the following:

- An assessment of whether each of the standards has been met.
- Areas of strengths and any areas of concern for each of the standards
- Findings/conditions, if any, that need to be addressed to meet/comply with the standard and the associated timeframe.
- Recommendations for further improvement.
- Overall reaccreditation rating.

The draft report is sent for review and identification of factual errors to the Director(s)/Head(s) of O&G and the Chief Executive Officer. Any such comments must be submitted to the Chair of the RANZCOG TAC within one month of the date on which the draft report is received. The final report is then submitted to the RANZCOG Board for consideration with respect to approval.

Once approved by the RANZCOG Board, the report is then forwarded to the Director(s)/Head(s) of O&G, the Chief Executive Officer/Manager, the ITP Coordinator(s) and the relevant Regional TAC Chair. A précis of the report including the accreditation rating is sent to Training Supervisors and trainees at the site.

Hospitals have the right to appeal the RANZCOG's reaccreditation rating under RANZCOG's appeals procedures.

Where a hospital has been given a further period of provisional accreditation due to inadequate progress against the accreditation standards and conditions/recommendations imposed, the follow-up visit and report will focus on whether those conditions and recommendations have been met. When this occurs, hospitals will not be sent a draft report for comment.

Accreditation Outcomes

The assessment of compliance against accreditation standards specifies whether the site has 'met', 'partially met' or 'not met' each of the minimum requirements under the accreditation standards. The accreditation report will identify any conditions and/or recommendations for further improvement. The possible accreditation outcomes are as follows:

Full Accreditation

Full Accreditation for a period of four years is given to those sites that meet all RANZCOG accreditation standards. There may still be recommendations for further improvement under this rating with a requirement to provide progress reports addressing progress in relation to accreditation recommendations. If progress is deemed satisfactory, the hospital retains full accreditation for the remainder of the accreditation period.

If there is any indication a training site may be experiencing difficulties in meeting accreditation standards, the accreditation rating may be reviewed.

Provisional Accreditation

Provisional accreditation is given to those sites that meet some, but not all, of the RANZCOG accreditation standards. The period for which provisional accreditation is granted will be determined by the findings of the accreditation team in relation to each standard and the conditions necessary to meet that standard. Periods of provisional accreditation range from six to 24 months with measures in relation to monitoring and progress reports also identified.

If progress reports demonstrate that the accreditation standards are met, accreditation is upgraded to full accreditation for the remainder of the four-year accreditation cycle.

If progress reports indicate some progress towards compliance with conditions and/or recommendations, but not all standards have been met or inadequate progress or deterioration, provisional accreditation will be retained by the site. Further consideration will be given to additional monitoring measures such as progress reports and, if necessary, a site visit prior to the expiry of the provisional accreditation period.

If additional progress reports and a site visit still demonstrate non-compliance with accreditation standards and conditions/recommendations, provisional accreditation will be extended for a further limited period, with the site advised that the possible outcome may result in the loss of accreditation.

Loss of Accreditation

Loss of accreditation occurs when a training site has been unable to meet the accreditation standards or satisfactorily demonstrate progress towards compliance with the standards or addressing conditions of accreditation.

RANZCOG recognises that any response needs to be well considered otherwise it can potentially be detrimental not only for a health service but for trainees and supervisors. Prior to any formal action, RANZCOG will investigate further the issues through the gathering of information and informal discussions with key stakeholders as well as assesses where the hospital is in its accreditation cycle. Depending on circumstances, re-accreditation may be brought forward and the standard process of re-accreditation applies.

When there is a recommendation to withdraw accreditation, the training site will be invited to respond in writing to the findings of the accreditation team before a final decision is made by the RANZCOG Board. The training site and relevant Regional TAC will be notified of the details of the decision to allow time for



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alternative rotation arrangements to be made for trainees at the training site. When a training site has accreditation withdrawn, trainees are not permitted to begin a new six-month rotation at the training site until accreditation has been regained. Current trainees may be allowed to complete a current six-month block of training at that site, this is at the discretion of RANZCOG.

Accreditation Evaluation, Monitoring and Review

RANZCOG has an ongoing process for monitoring and evaluating the effectiveness of training provided to trainees, which includes the following:

- Compulsory online six-monthly questionnaires for all trainees.
- Compulsory exit survey for trainees completing the FRANZCOG Training Program.
- Survey of new Fellows 12 months after completing the FRANZCOG Training Program.
- Annual survey of FRANZCOG ITP Coordinators and Training Supervisors.
- Reports delivered by Regional TAC Chairs at RANZCOG TAC Meetings.
- Monitoring of procedural numbers through the trainee online portfolio.

Should serious concerns be raised that indicates a training site is not meeting accreditation standards, accreditation will be reviewed.

Evaluation of the accreditation processes is not currently formalised.

Accreditation Review

An Accreditation Working Group was convened in 2019 to develop a model of accreditation that supports a Quality Improvement approach. The working group will also review the existing accreditation, quality assurance and improvement processes to develop efficiencies, increasing transparency and improving the effectiveness of the accreditation processes across the FRANZCOG training programs.

Under the review there will be consideration on moving away from four yearly cycles of accreditation with formal visits to more contemporaneous accreditation with a risk based, data-driven accreditation approach and visits as required.

Accreditation Data Management

RANZCOG have an online portfolio system called 'MyRANZCOG'. Trainees use this system for recording their daily logbook records. The surgical procedure numbers in all units are collected via that system and made available to ITP Coordinators and Regional Training Accreditation Committees at regular intervals. This information is also used for accreditation purposes.

RANZCOG has approximately three years of data. Accreditation visit assessments are paper-based currently.

Appendix H1: RANZCOG Training Program Standards and Criteria

Accreditation standards and criteria are provided below, and further details on minimum requirements under each criteria can be found on the RANZCOG website.¹⁴²

RANZCOG Accreditation Standards and Criteria

Standard 1 Support for RANZCOG Officers and Engagement With Hospital Accreditation Processes

Criteria:

1.1 The hospital supports the work of the relevant ITP Coordinator/s and State / Territory / New Zealand TACs.	<p>1.1.1 Access for the ITP Coordinator: The hospital, and the O&G Department in particular, allows reasonable access for the ITP Coordinator/s to liaise with FRANZCOG trainees, Training Supervisors and other relevant consultants so as to ensure that the planned program of teaching and experiences for FRANZCOG trainees is implemented and appropriately supported.</p> <p>1.1.2 Assisting with the provision of trainee experiences in subspecialty and other domains: The hospital works with the ITP Coordinator to ensure that, within the ITP, sufficient opportunities are provided to trainees to cover all aspects of the training program.</p> <p>1.1.3 Training Supervisor liaison with ITP Coordinator and State / Territory / New Zealand TAC Chair: Training Supervisors liaise closely with the relevant ITP Coordinator and / or State / Territory / New Zealand TAC Chair, proactively where possible, to discuss training issues and problems, particularly where the hospital is unable to provide FRANZCOG trainees with the clinical experience or support needed to meet the requirements of the FRANZCOG Training Program.</p>
1.2 Where a RANZCOG ITP Coordinator is employed by the hospital, they are provided with a minimum of one paid and protected session per fortnight to enable them to carry out their duties effectively.	<p>1.2.1 Hospital Support: <i>NB This criterion applies only to home / base hospitals where an ITP Coordinator is employed.</i> The ITP Coordinator is provided with a minimum of one paid and protected session per fortnight and suitable administration support by the hospital to allow satisfactory performance of their duties. The special responsibilities of the ITP Coordinator are acknowledged in their employment contract and position description, including the provision of this paid and protected time. Payment for this time can be in addition to the Supervisor's salary or factored in as part of the contracted salary.</p>

¹⁴² FRANZCOG Accreditation Standards and Guidelines for Hospitals in the FRANZCOG Training Program, Process and Criteria, v1.7 November 2021, https://ranzco.edu.au/RANZCOG_SITE/media/RANZCOG-MEDIA/Training%20and%20Assessment/Specialist%20Training/Hospitals/FRANZCOG-Accreditation-Standards-and-Guidelines-for-Hospitals.pdf



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1.3 The hospital engages with and facilitates training site accreditation processes.	<p>1.3.1 Accreditation visits:</p> <p>The hospital, in the person of the O&G Director, responds in a timely manner to RANZCOG Accreditation Team requests in relation to an accreditation visit:</p> <ul style="list-style-type: none"> • In setting and agreeing visit date/s • In completing pre-visit hospital questionnaires and other documentation to meet required timelines • In drafting and finalising visit timetables to ensure trainees, consultants and other hospital staff are available to be interviewed at appropriate times. <p>1.3.2 Progress reports and other interactions:</p> <p>The hospital completes required accreditation progress reports to meet required deadlines, and with comprehensive information.</p> <p>The hospital responds to all other accreditation queries in a timely fashion.</p>
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Standard 2 Appointment and Support of Training Supervisors

Criteria:

2.1 An appropriate number of Training Supervisors has been appointed to ensure FRANZCOG trainees receive effective education and clinical supervision.	<p>2.1.1 Ratio of Training Supervisors and Onsite Presence:</p> <p>Training Supervisors have been appointed to ensure there is at least one Training Supervisor to every four FRANZCOG trainees. Each Training Supervisor is available onsite on a regular weekly basis, and holds a minimum of a 0.2 FTE contract at the hospital where their allocated FRANZCOG trainees are employed.</p>
2.2 Training Supervisors receive support from the hospital to undertake their supervisory roles.	<p>2.2.1 Support for Training Supervisors:</p> <p>Training Supervisors are given sufficient paid and protected supervision/teaching time to enable them to carry out their duties effectively. This paid / protected time is calculated as at least 10 hours annually per FRANZCOG trainee supervised. The special responsibilities of the Supervisor are acknowledged in their hospital contract and Position Description, including the provision of this paid and protected time.</p>
2.3 Training Supervisors undertake training in order to perform their supervisory role.	<p>2.3.1 Training Supervisor Workshops:</p> <p>Training Supervisors must attend a RANZCOG Training Supervisors' Workshop during their first year as a Training Supervisor. It is recommended that Training Supervisors attend refresher workshops and / or undertake other upskilling activities every three years thereafter to ensure they are up to date with curriculum and assessment changes.</p>

	2.3.2	<p>Clinical Educator Training (CET) Modules:</p> <p>New Training Supervisors undertake the eight CET online interactive modules that are located on the RANZCOG eLearning platform as part of the application process. The modules cover a range of topics relevant to teaching, supervising and mentoring, including the principles of workplace-based training and assessment, effective communication, different teaching and learning styles, effective teaching practice, performance appraisal and how to conduct meaningful assessments to provide useful feedback.</p>
2.4 Training Supervisors carry out their roles and responsibilities as outlined in the RANZCOG Training Supervisor Position Description.	2.4.1	<p>Roles and Responsibilities:</p> <p>Training Supervisors are familiar with and perform the roles and responsibilities required of a RANZCOG Training Supervisor including conducting the three-monthly Appraisal and six-monthly Assessment Reports, as per the RANZCOG Training Supervisor Position Description – Roles and Responsibilities document, available on the RANZCOG website at: https://www.ranzcog.edu.au/Training/Specialist-Training/Supervisors-Coordination</p>
	2.4.2	<p>Training Program Requirements:</p> <p>Training Supervisors are familiar with the content and requirements of the FRANZCOG Training Program as set out in the RANZCOG Regulations and the FRANZCOG Curriculum documents available on the RANZCOG website at, respectively: https://www.ranzcog.edu.au/Our-College/Governance/Constitution-Regulations https://www.ranzcog.edu.au/Training/Specialist-Training/Curriculum-Handbook</p>
	2.4.3	<p>Rosters:</p> <p>In consultation with the Director(s)/Head(s) of O&G, Training Supervisors are responsible for ensuring that rostering arrangements are made in conjunction with Consultants and Advanced trainees familiar with the specific needs of FRANZCOG Basic trainees.</p>

Standard 3 Consultant Involvement With and Support for FRANZCOG Trainees

Criteria:

3.1 There is an adequate number of senior medical staff to provide effective training, support and supervision of FRANZCOG trainees.	3.1.1	<p>Full-Time Staff Specialist or Academic O&G Specialist:</p> <p>The hospital employs a minimum of two RANZCOG Fellows as members of staff.</p> <p>For hospitals undertaking more than 3000 births, there is at least one full-time Staff Specialist in O&G or full-time Academic O&G Specialist.</p> <p>There is an appropriate FTE of O&G to meet the clinical workload including after-hours clinical requirements.</p> <p>The hospital has sufficient O&G Consultant FTE to support, sustain and deliver the FRANZCOG Training Program, in addition to service provision requirements.</p>
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	3.1.2	<p>Consultant Staff:</p> <p>The hospital has sufficient Consultant FTE, determined by the workload and number of Registrars and Residents, to cover the following areas:</p> <ul style="list-style-type: none"> • 24-hour birthing suite supervision (whether onsite or on-call). • Teaching, supervision and mentoring of FRANZCOG trainees in obstetrics and gynaecology. • Regular and active involvement in a Structured Educational Program, which includes making formal presentations on a rostered basis and regular attendance at sessions to provide a strong Consultant presence and involvement in discussions. • Coordination of audit activities in both obstetrics and gynaecology. • Supporting FRANZCOG trainees' compulsory research activities. 	
3.2	FRANZCOG Consultants are actively involved and engaged in the teaching and training of Registrars in theatre, clinics and on the wards and birthing suite.	3.2.1	<p>Consultant position description or statement of duties:</p> <p>Each Consultant's position description or statement of duties clearly stipulates the requirement for Consultants to teach and supervise FRANZCOG trainees. A sample position description or statement of duties should be available for review by the RANZCOG Accreditation Panel during an accreditation visit.</p>
		3.2.2	<p>Appropriate Consultant Support:</p> <p>A Consultant is always available to attend the birthing suite in a timely manner when requested by any trainee, or when the clinical circumstances indicate that attendance is warranted.</p> <p>A Year 1 FRANZCOG trainee rostered to cover labour ward has the continuous presence of a more senior trainee or Consultant at all times on the labour ward until they are credentialed by the hospital to manage birth suite without continuous senior presence.</p>
		3.2.3	<p>Appropriate After-Hours Supervision and Teaching:</p> <p>FRANZCOG trainees have immediate access to the duty Consultant for advice and, where appropriate, their physical presence, to assist with decision making, for the supervision and assistance of procedures, and for teaching and training opportunities.</p> <p>Each FRANZCOG trainee with less than two years' postgraduate experience in obstetrics and gynaecology who is rostered on night duty has adequate supervision by an onsite (or immediately available – within five minutes) Consultant or more experienced Registrar, even when the FRANZCOG trainee has been credentialed by the hospital to perform specific procedures without direct onsite supervision.</p>
		3.2.4	<p>On-call Arrangement:</p> <p>As many Consultants as is reasonable are involved in the on-call arrangements to assist in lowering the individual loads and to facilitate provision of educational opportunities for FRANZCOG trainees.</p>

All Consultants on the on-call roster are available to physically attend within 30 minutes at all times, or are contractually required to stay overnight when on-call and are provided with appropriate accommodation.

3.2.5 Team Structure:

Hospitals have a planned team / unit structure which ensures a high quality and continuity of patient care whilst maximising teaching, learning and training opportunities.

NB Training sites with fewer than five trainees are not obligated to meet this criterion.

3.2.6 Role of the Consultant:

Designated Consultants have day-to-day responsibility for effective supervision and training, including:

- Treating FRANZCOG trainees with respect and courtesy.
- Providing regular constructive feedback.
- Taking FRANZCOG trainees through each new procedure and giving adequate opportunities to practise their skills.
- Taking every opportunity to complete formative and summative Assessments of Procedural and Surgical Skills (APSSs) as appropriate, using the designated WBA forms.
- Close observation of each FRANZCOG trainee's practice and training, including their pre-operative assessment of a case, intra-operative performance, and post-operative care.
- Involving FRANZCOG trainees in case follow-up and appropriate documentation.
- Daily attendance at morning birthing suite handovers and gynaecology ward rounds, including weekends.
- Involvement in credentialing of FRANZCOG trainees.
- Involvement in the structured In-Hospital Education Program, including leading case presentations and perinatal mortality and morbidity sessions.
- Assisting FRANZCOG trainees to improve their communication and decision-making skills.
- Listening to FRANZCOG trainees' concerns about training and responding respectfully.
- Contributing to the formal assessment of FRANZCOG trainees, through completion of RANZCOG Consultant Assessment of Trainee Forms, available on the RANZCOG website at: <https://ranzcof.edu.au/training/specialist-training/login-online-portfolio> and providing the Training Supervisor with an objective and fair assessment of a FRANZCOG trainee's performance and progress.

3.2.7 Consultant Support in Clinics:

A Consultant or Advanced trainee is continuously present in all clinics attended by Basic FRANZCOG trainees. Where the Advanced trainee is the most senior person in the clinic, a consultant must be available by phone for consultation.



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Standard 4 Provision of Clinical Supervision and Experience

4A: General

Criteria:

4A.1	Trainees are provided with the appropriate clinical supervision and experience to meet training program requirements and to ensure the progression of clinical competence from 'novice' to 'proficient'.	4A.1.1	<p>Clinical Experience:</p> <p>Trainees are provided with the clinical experience and opportunities to enable them to meet training program requirements.</p> <p>Access to training experience in Subspecialist / special interest disciplines is not limited because of Subspecialty / special interest trainees.</p> <p>Training experience is not compromised by Registrar, Senior Registrar or Fellow positions occupied by non-FRANZCOG trainees, or those in a short term training pathway.</p>
		4A.1.2	<p>Assessment of Procedural and Surgical Skills (APSS):</p> <p>Consultants teach and provide appropriate feedback to FRANZCOG trainees undertaking their formative and summative APSS workplace-based assessments as required by the RANZCOG Regulations and FRANZCOG Curriculum, and relevant to a FRANZCOG trainee's year level in the FRANZCOG Training Program.</p>
		4A.1.3	<p>Increased Responsibilities:</p> <p>Clinical responsibilities and training opportunities increase in complexity as the FRANZCOG trainee progresses through the FRANZCOG Training Program.</p>
		4A.1.4	<p>Roster Requirements – Basic Trainees:</p> <p>Rosters for Basic trainees ensure regular sessions in the following (noting that smaller sites may not be able to offer all components and that coverage of these components is determined as part of ITP rotation arrangements):</p> <ul style="list-style-type: none"> • Full day in the birthing suite • General gynaecological surgery (including operative laparoscopy) • Caesarean section list • Antenatal clinic • Gynaecological clinic • Antenatal, postnatal and gynaecology ward rounds • Minor procedures • Ultrasound • Colposcopy • Pre-admission clinic • Involvement in the continuity of care from admission to discharge • Family planning (clinics and relevant surgical opportunities) <p><i>In Australia:</i></p> <p>In line with the Medical Practitioners Award 2020, trainees are given at least two weeks' notice of rosters to be</p>

worked in relation to ordinary hours, including additional (overtime) rostered hours. It is noted that, on occasion, rosters may need to be changed without notice to meet emergency situations.

In New Zealand:

In line with the Multi-Employer Collective Agreement (MECA), trainees are given at least four weeks' notice of rosters.

4A.1.5 Support by Colleagues and Juniors for FRANZCOG Trainees, including After Hours:

FRANZCOG trainees are not required to provide cover for both the birthing suite and Accident and Emergency when working on their own after hours in a hospital with more than 2000 births per year.

FRANZCOG trainees working after hours on the birthing suite are provided with support, at a minimum, by a Hospital Medical Officer / House Officer in at least their second postgraduate year (i.e. PGY2 – not an Intern) to enable them to safely perform their clinical responsibilities and maximise available training opportunities:

- > 2000 births: 24-hour cover (particularly where the FRANZCOG trainee is expected to concurrently cover emergency, antenatal/gynaecology ward and the postnatal ward)
- 1000–2000 births: 8am to 10pm
- < 1000 births: not required.

After a short period of instruction, Hospital Medical Officers are able, at a minimum, to:

- Take blood and insert intravenous cannulas
- Conduct initial assessments by taking an appropriate clinical history
- Perform vaginal and speculum examinations
- Assist with episiotomy repairs
- Assist in emergencies
- Assist in theatre
- Handle drug orders / prescriptions.

In smaller hospitals with less than 2000 births per year, the night Registrar may be required to cover the birthing suite and also see acute O&G cases in Accident / Emergency / Women's health assessment if appropriate.

4A.1.6 Experience in Clinics:

FRANZCOG trainees at tertiary and home/base hospitals are provided with experience in the care of a broad range of ambulatory (outpatient) cases as well as those presenting with urgent problems. Each FRANZCOG trainee is given the opportunity, under the supervision of a Consultant, to provide an initial assessment and consultative service to patients presenting with emergency conditions. At training sites where the provision of outpatient services has been delegated to the private sector or Consultants' rooms, the



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FRANZCOG trainee is provided with opportunities to act as the primary clinician with appropriate oversight.

Rosters for FRANZCOG trainees at all training sites ensure that the FRANZCOG trainees have the maximum available experience, including access to gynaecology, colposcopy, antenatal and pre-operative anaesthetic clinics.

4A.1.7 Policies, Procedures and Clinical Guidelines:

All policies, procedures and clinical guidelines relevant to O&G are regularly reviewed and revised, and consistently followed by all Consultants to an auditable standard.

4A.1.8 Birthing Suite Handover:

The morning birthing suite handover is utilised as an educational opportunity for FRANZCOG trainees (noting operational requirements) and includes proactive planning and triaging.

Consultants take opportunities as they arise to highlight valuable learning points and provide constructive feedback to trainees (with negative feedback provided separately and individually, rather than in this public forum). In a tertiary hospital, the Consultant on duty, the Senior Registrar and the Team Leader / Midwife are present at handovers. The handovers are multidisciplinary and frequently include a Paediatrician and Anaesthetist. Respectful discourse is a key feature of handover.

4A.1.9 Training in Expanded Settings:

Patient consent:

Where FRANZCOG trainees utilise training in an expanded setting, including consultants' private rooms, informed patient consent is obtained for all procedures in which FRANZCOG trainees are involved.

Insurance:

The training site also ensures that medical indemnity insurance is in place for both the FRANZCOG trainee and the Consultant undertaking the training / supervising activities.

4A.1.10 FRANZCOG Trainee In-Hospital Credentialing:

The hospital has a documented credentialing process in place to identify each FRANZCOG trainee's competence in relevant obstetric and gynaecological surgical procedures. The In-Hospital Credentialing process is the responsibility of the Director(s) / Head(s) of O&G in consultation with the Training Supervisor and in collaboration with Consultants, Advanced trainees (where relevant) and other relevant Health Practitioners.

The hospital may develop its own credentialing process or utilise that of the RANZCOG In-Hospital Credentialing document, available on the RANZCOG website at: https://ranzco.edu.au/RANZCOG_SITE/media/RANZCOG-MEDIA/Training%20and%20Assessment/Specialist%20Training/Hospitals/Registrar-In-House-Credentialing.pdf

The hospital may also have a list of procedures where the Consultant must always be present. If this exists, it

	<p>supersedes the level of credentialing of any individual FRANZCOG trainee.</p> <p>The credentialing document specifies the level of supervision each FRANZCOG trainee requires for specific procedures particularly where these are performed after hours. If a FRANZCOG trainee is listed as requiring after hours direct supervision for a particular procedure, the on-call Consultant attends.</p> <p>Regardless of the credentialing for a particular procedure, FRANZCOG trainees feel comfortable to seek assistance from a Consultant(s), who provides support when requested to do so.</p> <p>The credentialing document is distributed to all relevant Staff, such as Consultants, including Locums, Senior Midwifery and Theatre Staff, Advanced trainees and Theatre Nurses. All relevant staff adhere to the level to which an individual FRANZCOG trainee is credentialed.</p> <p>The credentialing document is reviewed and updated for each FRANZCOG trainee every six months at a minimum. For Basic trainees, where necessary, and in addition to their own credentialing processes, hospitals other than the home / base hospital verify with the home / base hospital the credentialing of their allocated FRANZCOG trainee(s).</p>
<p>4A.2 Advanced trainees are provided with the appropriate clinical opportunities to enable them to undertake either a 'Generalist' or 'Non-Generalist' Pathway and relevant Advanced Training Modules (ATMs) during their Advanced Training.</p>	<p>4A.2.1 Advanced Clinical Experience: Advanced trainees are provided with the clinical experience and opportunities to enable them to meet the requirements of Advanced Training, including any relevant ATMs.</p> <p>4A.2.2 Professional Attributes: Advanced training positions have a defined role that includes most of the following:</p> <ul style="list-style-type: none"> • Administration • Rostering of junior staff • Involvement in audit • Organisation and performance of education activities for Medical Students, FRANZCOG trainees and other clinical staff who are not FRANZCOG trainees • Recognised role in the training and assessment of Basic trainees • Participation as appropriate in Departmental Consultant Meetings • Involvement in the development of policies, procedures and clinical guidelines.
<p>4A.3 Training Sites have a Patient Consent form that allows for patient information to be used for training purposes.</p>	<p>4A.3.1 Patient Consent: Training sites have Patient Privacy / Consent processes and associated forms that include a statement acknowledging that patient information can be used for training purposes.</p>



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4B: Gynaecology

Criteria:

4B.1 Trainees are provided with sufficient gynaecological surgical experiences, under appropriate supervision, to meet training requirements and to ensure the progression of surgical competence from 'novice' to 'proficient'.	<p>4B.1.1 Gynaecological Surgery Lists</p> <p>The hospital provides FRANZCOG trainees with sufficient gynaecological surgical experience as the Primary Operator to meet training program requirements. For Basic trainees, this is in line with <i>Guidelines for Hospitals in the FRANZCOG Training Program: Gynaecological Surgical Training</i>. Hospitals should refer to the associated document <i>Strategies for training hospitals to improve trainee gynaecological surgery procedure numbers</i> available on the College website.</p> <p>4B.1.2 Primary Operator Experience – Basic trainees:</p> <p>FRANZCOG trainees are given maximum opportunities and experience as the Primary Operator by Consultants and / or Advanced trainees, having regard to year level and abilities, and also are given opportunities to utilise training in expanded settings (e.g. private settings).</p> <p>4B.1.3 Primary Operator Experience – Advanced trainees:</p> <p>Advanced trainees are provided with opportunities to reach a high level of independence in the performance of procedural and surgical skills, which necessitates:</p> <ul style="list-style-type: none"> • Primary Operator experience, with a junior assistant, for those procedures where remote supervision credentialing level has been achieved. • Primary Operator experience with in-theatre supervision for those procedures where onsite or remote credentialing level has not yet been achieved. • Supervising Basic trainees who are acting as the Primary Operator. <p>4B.1.4 Priority Access to O&G Theatre Lists:</p> <p>FRANZCOG trainees have priority access to O&G theatre lists over other junior medical staff who are not FRANZCOG trainees, and those in a short term training pathway. This priority is reflected in the roster and position descriptions of FRANZCOG trainees.</p>
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4C: Ultrasound

Criteria:

4C.1 Structured ultrasound training is in place to enable FRANZCOG trainees to meet the required competencies, including completion of their Ultrasound Assessment of Procedural and Surgical Skills (APSS)	4C.1.1 Ultrasound:
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Ultrasound Training Time:

The hospital provides FRANZCOG Basic trainees with sufficient ultrasound training time to meet training program requirements, in line with *Guidelines for Hospitals in the FRANZCOG Training Program: Ultrasound Training*.

Ultrasound Workshop:

Basic trainees are required to complete a RANZCOG-approved internal or external course or workshop by the end of 92 weeks of Basic Training. The training site must allow and support trainees' attendance at such a workshop.

4D: Colposcopy

Criteria:

4D.1 Structured colposcopy training is in place to enable FRANZCOG trainees to meet the required competencies, including completion of their Colposcopy In-Hospital Clinical Assessments (IHCA)	4D.1.1 Colposcopy: Basic trainees are rotated through attachment to a colposcopy service, with sufficient caseload and continuity of exposure to both new and review cases to enable them to obtain the skills required to pass the Colposcopy IHCA or APSS.
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4E: Family Planning

Criteria:

4E.1 FRANZCOG trainees are provided with a range of opportunities and experiences in family planning, including surgical and relevant surgical opportunities	4E.1.1 Family Planning Clinics: Rosters for Basic trainees ensure regular sessions in family planning clinics (noting that smaller sites may not be able to offer this component).
	4E.1.2 Long Acting Reversible Contraception (LARC): Basic trainees are provided with appropriate training and experience in the insertion of intrauterine devices (IUDs) and contraceptive implants (Implanon / Jadelle).

Standard 5 Provision of Structured Education Programs, Teaching Sessions and Learning Opportunities

Criteria:

5.1 A comprehensive education program is provided that includes Consultant-led hospital teaching, rounds, lectures, case presentations, ultrasound teaching, mortality and morbidity meetings, journal club, discussions, audits and reviews is provided.	5.1.1 Coordination of Education Program: The Educational Program at the hospital is coordinated by a designated Consultant (or an Advanced trainee with oversight by a designated Consultant). Consultants are in regular attendance, make formal presentations on a regular basis and utilise cases for interactive teaching.
	5.1.2 Education Program Content: If the hospital is a home / base hospital, a comprehensive and coordinated Consultant-led formal educational program is provided, covering an extensive range of obstetric and gynaecological topics and other learning opportunities. The program timetable includes interprofessional and multidisciplinary education opportunities and at a minimum, the following on a regular basis: <ul style="list-style-type: none"> • Tutorials and / or FRANZCOG trainee case presentations • Journal club



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- Complex gynaecology case reviews, cervical pathology meetings
- Regular perinatal, neonatal and maternal mortality and morbidity meetings
- Cardiotocography (CTG) audit meetings and intra partum management tutorials
- Complex obstetric case review meetings
- Obstetrics and gynaecology teaching rounds
- Emergency Obstetrics Training.

If a hospital is a small urban or rural training site, a structured though less comprehensive Education Program is provided at least monthly. The program timetable includes as a minimum:

- Regular Consultant-led teaching sessions
- Combined case review meetings – FRANZCOG trainees present a review/audit on interesting or complex cases
- Regular perinatal mortality and morbidity meetings (at least three-monthly), coordinated by a FRANZCOG trainee with designated Consultant support.

5.1.3 Safety and Quality; Governance Participation:

FRANZCOG trainees are given opportunities to participate in hospital committees such as Occupational Health and Safety (OH&S), Clinical Audit, Mortality and Morbidity, Quality Assurance and Clinical Governance.

5.2 Rostering arrangements and strategies are in place to ensure that all FRANZCOG trainees have protected time to attend education sessions. FRANZCOG trainees are not rostered for other duties when education sessions are scheduled, except for the provision of emergency cover.

5.2.1 Paid and Protected Non-Clinical Time: *Training / Teaching Time*

FRANZCOG trainee timetables include a minimum of four hours per fortnight (four hours per week is recommended) paid and protected training/teaching time to attend and/or conduct educational sessions. Arrangements are in place to ensure that Basic trainees are able to attend educational sessions. This may include designation of Consultants, Advanced trainees or non-FRANZCOG trainees to hold the Basic trainees' pagers and cover the birthing suite or the clinics at these times.

Research / Study / Clinical Audit Time

FRANZCOG trainees are allocated a minimum of four hours per fortnight paid and protected research / study / clinical audit time in addition to protected time for attendance at in-hospital education sessions. This is to be provided regardless of whether there is an existing jurisdictional obligation to provide this time for FRANZCOG trainees.

Administration Time

In addition to the above allocations, FRANZCOG trainees are afforded sufficient paid time within their normal roster to undertake administrative responsibilities.

5.3 Formal basic obstetric skills training sessions are provided for all Year 1 FRANZCOG trainees.	5.3.1	<p>Basic Obstetric Surgical Skills Training:</p> <p>Formal teaching sessions in basic obstetric skills are provided by designated Consultants in accordance with the RANZCOG Basic Obstetric Surgical Skills Workshop: Trainees' Manual.</p> <p>Where this does not occur, the hospital arranges for any Year 1 FRANZCOG trainees to attend such workshops / sessions in another hospital within the ITP.</p>
5.4 Simulation training is offered to all FRANZCOG trainees.	5.4.1	<p>Simulation Training:</p> <p>Trainees are rostered to regularly utilise simulation activities and equipment on or offsite to increase their skills, confidence and dexterity.</p> <p>FRANZCOG trainees at tertiary and home base hospitals have access to simple basic skills training equipment including as a minimum a box trainer and appropriate instruments, and pelvic model appropriate to train in instrumental birth and obstetric manoeuvres.</p> <p>The equipment is to be available in an area that is accessible out of regular working hours and accompanied by an appropriate curriculum to guide learning.</p> <p>Suburban and rural sites are encouraged to offer simulation training opportunities wherever possible.</p> <p>At sites where simulation equipment is available, a Consultant or Advanced trainee is nominated to coordinate simulation activities within the program, ensure equipment is maintained and ensure equity of access to trainees from all sites in the ITP.</p>
5.5 FRANZCOG trainees have the opportunity to attend external education activities, meetings, courses and workshops.	5.5.1	<p>External Education Program:</p> <p>FRANZCOG trainees are given opportunities to attend external education activities, meetings, courses and workshops, including education sessions conducted at nearby RANZCOG-accredited training sites. Consideration is given by the hospital to reimburse or partially reimburse costs involved in attending relevant conferences and workshops that will assist a FRANZCOG trainee's knowledge, skills and level of understanding to meet learning objectives of the training program.</p>
5.6 FRANZCOG trainees are provided with regular opportunities to teach prevocational medical staff and medical students.	5.6.1	<p>Teaching Residents and Medical Students:</p> <p>Advanced trainees are rostered onto the tutorial program for Basic trainees, prevocational trainees and / or medical students and regularly give tutorials. FRANZCOG trainees are involved in one-on-one teaching with Residents on the ward and in theatre where such an arrangement is feasible and appropriate.</p>



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5.7 FRANZCOG trainees undertaking Advanced Training are provided with additional educational opportunities.	<p>5.7.1 Advanced Courses, Workshops and Academic Development: Advanced trainees are given opportunities to attend specific courses appropriate to their training plan or area(s) of special interest.</p> <p>5.7.2 Teaching and Assessing of FRANZCOG Basic trainees: In addition to teaching residents and medical students, Advanced trainees have a formalised and recognised role in the training of Basic trainees, including the assessment of the procedural and surgical skills that need to be signed off by the end of Year 1 and Year 2 of Basic Training.</p> <p>5.7.3 Administration Duties: Advanced trainees are involved in some or all of: rostering of junior Staff, Department audits, organisation and performance of educational activities for medical students, prevocational trainees, DRANZCOG trainees, FRANZCOG trainees and participation as appropriate in Departmental Consultant Meetings and policy development for the unit.</p>
5.8 In hospitals with five consultants or more, at least one Consultant is a FRANZCOG Examiner, or has been within the last 10 years.	5.8.1 FRANZCOG Examiners: In hospitals with five consultants or more, at least one Consultant is a FRANZCOG Examiner, or has been within the last 10 years. This is to ensure that teaching and learning focuses on the knowledge, skills, professional qualities and competencies expected and which are assessed informally and formally throughout the training program both within the hospital and through the examinations.
5.9 The O&G Department provides an adequate range of education resources to support the learning environment.	5.9.1 Facilities for FRANZCOG trainees: FRANZCOG trainees are provided with appropriate facilities including: <ul style="list-style-type: none"> • Internet access • Ready access to supportive software such as evidence-based clinical decision support tools (e.g. UpToDate) and medical databases (e.g. Medline) with relevant passwords where required. • On-line access to relevant electronic journals and extensive and up-to-date library collections. • A fully equipped, appropriately sited and resourced space for the sole use of trainees.
5.10 Research opportunities and support and protected research/study time are provided to FRANZCOG trainees to undertake private study and their compulsory research project.	5.10.1 Research Support and Commitment to Research: FRANZCOG trainees are provided with research opportunities with appropriate guidance, mentoring and supervision. The provision of research support and opportunities includes: <ul style="list-style-type: none"> • Identification of individual/s on staff to provide support, advice and guidance to FRANZCOG trainees to undertake their compulsory research projects.

		<ul style="list-style-type: none"> • Identification of a range of research possibilities for FRANZCOG trainees including but not limited to systematic reviews for publication in the Cochrane Library, systematic literature reviews, case reports and local audits. • Opportunities to present research projects in peer-reviewed journals, at conferences and Annual Scientific Meetings (ASM). <p>It is expected that major teaching hospitals and peripheral training sites will offer a greater range of experiences and support to FRANZCOG trainees in relation to research, providing opportunities for trainees to participate in additional research activities, including obstetric audits and assisting in the review and writing of protocols.</p>
5.11	The hospital provides an easily accessible obstetric database to assist FRANZCOG trainees with audit and research.	5.11.1 Obstetric Database: FRANZCOG trainees can easily access an obstetric database to assist with audit and research.
5.12	The O&G Department conducts regular minuted Consultant meetings.	5.12.1 Consultant Meetings: The O&G Department holds regular minuted meetings with Consultants and Registrars that address matters such as policy development, training, education, safety and quality and administration. This may be through the attendance by a nominated Senior Registrar at regular senior staff meetings, or communication of policy decisions through a regular bulletin or email. The O&G Department holds regular minuted inter-professional meetings that provide opportunities for members of the multi-disciplinary team to discuss relevant matters, including any issues that may be impacting on the health and well-being of FRANZCOG trainees.

Standard 6 Workplace Culture, Registrar Staffing, Safe Working Hours, Leave Arrangements and Assistance for Rural Rotations

Criteria:

6.1	A supportive, harmonious workforce culture and team environment is evident.	6.1.1 Consultants and Workplace Culture: Consultants contribute to a workplace culture that is harmonious, respectful and supportive of training and the delivery of up-to-date, evidence-based care. Consultants conduct themselves in a professional manner and treat FRANZCOG trainees with respect and courtesy.
		6.1.2 Organisational Culture: The leadership and organisational culture is supportive and harmonious. Teamwork and morale are strong and this culture is propagated amongst the Medical, Midwifery, Nursing, Allied Health Staff and Management with constructive inter-professional relationships encouraged.
		6.1.3 Bullying, harassment and discrimination: The training site has zero tolerance for workplace bullying, harassment and discrimination.



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		<p>The training site has comprehensive policies and processes to identify, investigate and resolve issues of workplace bullying, harassment and discrimination. Consultants, FRANZCOG trainees and other hospital Medical Officers are trained in recognising and dealing with instances of workplace bullying, harassment and discrimination and conduct themselves in a professional manner in accordance with the publications of the Australian Medical Council (AMC) and the Medical Council of New Zealand (MCNZ) relating to good medical practice for Australian and New Zealand doctors available on the following websites at, respectively: https://www.amc.org.au/about/good-medical-practice https://www.mcnz.org.nz/news-and-publications/good-medical-practice/</p> <p>Mechanisms are in place to identify and assist FRANZCOG trainees who may be experiencing personal and / or professional difficulties that may in turn be affecting their training.</p>	
	6.1.4	<p>Support for trainees in difficulty:</p> <p>Mechanisms are in place to identify and assist FRANZCOG trainees who may be experiencing personal and / or professional difficulties that may in turn be affecting their training.</p>	
6.2	A suitable number of junior medical staff is employed to ensure sufficient training opportunities exist for FRANZCOG trainees to meet training requirements, over and above meeting service requirements.	6.2.1	<p>Trainee Staffing:</p> <p>Trainee numbers are such as to ensure FRANZCOG trainees receive adequate training opportunities as defined in the <i>FRANZCOG Curriculum</i> in addition to the hospital clinical service requirements.</p>
6.3	The hospital complies with award conditions relating to working hours and shift work relevant to the region in which it is located.	6.3.1	<p>Award Conditions – Working Hours:</p> <p>The hospital adheres to the relevant award conditions in relation to working hours and shift work prescribed under the Australian Medical Association (AMA) “National Code of Practice – Hours of Work, Shiftwork and Rostering Hospital Doctors”, individual Australian state / territory or New Zealand OH&S legislation, or stipulations of the New Zealand “Resident Doctors’ Association and 20 District Health Boards Multi-Employer Collective Agreement (17 May 2021 to 31 March 2024)” as applicable. Rosters are available to demonstrate compliance if requested.</p>
		6.3.2	<p>Guide to Appropriate Hours:</p> <p>RANZCOG recommends the following guide for hospitals:</p> <ul style="list-style-type: none"> • FRANZCOG trainee hours worked in a 14-day period complies with the appropriate award applicable in the relevant Australian state / territory or New Zealand. • The maximum length of a Registrar’s shift is generally no more than 14 hours. This maximum shift length is exclusive of on-call shifts, regardless of whether the on-call requires

		<p>onsite presence. In a hospital delivering less than 500 births annually, this may be extended to 24 hours.</p> <ul style="list-style-type: none"> • If occasional 24-hour shifts are undertaken, they are followed by a day off and only occur at hospitals where there is 24-hour Resident cover and ready availability of Consultant support. • Weekend rosters are organised on a minimum 1:3 basis. A 1:2 roster on a consistent basis is only used on occasion and only when staffing difficulties at a particular training site allow no other option. <p>RANZCOG acknowledges, in circumstances where there is easy access to Consultant support, some flexibility to the above guide is needed for smaller hospitals, particularly in rural areas where there is only one FRANZCOG trainee and they are required to be on-call over the weekend. Hospitals should refer to the associated guideline <i>Appropriate working hours for a FRANZCOG trainee</i> available on the College website.</p>	
	6.3.3	<p>Physical Safety and Security:</p> <p>FRANZCOG trainees working extended hours and / or subject to on-call and call-out arrangements which require them to attend and leave the hospital workplace at unusual hours, are provided with:</p> <ul style="list-style-type: none"> • Physical safety and security, such as lighting and escorts, when leaving work and reaching their car or transport at times well outside normal business hours. • Taxis or other transport when work-induced fatigue makes it unsafe for the trainee to drive home in their own car. 	
	6.3.4	<p>Arrangements for FRANZCOG trainees After Hours:</p> <p>FRANZCOG trainees working on-call from home after hours are available within 30 minutes and a rest room is provided and available onsite.</p>	
6.4	The hospital permits FRANZCOG trainees to undertake fractional training subject to the requirements of the hospital and prospective approval by the Chair of the relevant State / Territory / New Zealand TAC.	6.4.1	<p>Fractional Training:</p> <p>Subject to the staffing levels and the requirements of the hospital, and where approved by the Chair of the relevant State / Territory / New Zealand TAC and the hospital, FRANZCOG trainees are able to undertake fractional (part-time) training, defined as training undertaken between 0.5 FTE and 1.0 FTE. Where fractional training is undertaken, the clinical exposure experience is proportionately equivalent to the full-time position.</p>
		6.4.2	<p>Leave Arrangements:</p> <p>The hospital adheres to the relevant award conditions regarding minimum annual leave entitlements. Additionally, FRANZCOG trainees are afforded two weeks of study / conference leave per year, which is recognised as part of active clinical service.</p>
		6.4.3	<p>Training Whilst Pregnant:</p> <p>The hospital is supportive of, and familiar with, workplace policies and OH&S protocols relating to working while</p>



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		pregnant and accommodates FRANZCOG trainee requests where possible, as outlined in the Clinical training whilst pregnant statement available under Statements and Guidelines on the RANZCOG website at: https://www.ranzcog.edu.au/Statements-Guidelines
	6.4.4	<p>Training After Taking Leave:</p> <p>A supportive and comprehensive return to work program is provided, in accordance with RANZCOG Regulations in relation to time out of training.</p>
6.5	A mentor is offered and available if requested or recommended, in addition to the Training Supervisor.	<p>6.5.1 Mentor:</p> <p>The hospital facilitates the provision of an appropriate mentor if requested by the FRANZCOG trainee or if it is felt that a FRANZCOG trainee may benefit from the guidance and support of a mentor in addition to the Training Supervisor as outlined in the RANZCOG Mentoring Policy, available under Statements and Guidelines on the RANZCOG website at: https://www.ranzcog.edu.au/Statements-Guidelines</p> <p>Appropriate mentors may include health professionals outside of the O&G specialty.</p>
6.6	The hospital, if providing a rural rotation, provides appropriate accommodation for the duration of the rotation.	<p>6.6.1 Accommodation:</p> <p>The hospital, if providing a rural rotation, provides: Hospital accommodation or other subsidised accommodation, or assistance in obtaining suitable accommodation for the FRANZCOG trainee and their family.</p> <ul style="list-style-type: none"> • Removal expenses to and from the rural location. • Travel expenses to and from the rural location. • Funding for at least two home visits by the FRANZCOG trainee in each six-month period, equating to not less than 50% of the costs involved.
6.7	The hospital has in place a process for critical incident management, including the immediate and longer-term care of FRANZCOG trainees involved in critical incidents such as adverse maternal or peri-natal outcomes.	<p>6.7.1 Critical Incident Management:</p> <p>The hospital has strategies in place to support FRANZCOG trainee health and wellbeing and a process for critical incident management, including the immediate and longer-term care of FRANZCOG trainees involved in critical incidents such as adverse maternal or perinatal outcomes.</p>

Appendix I: The Royal Australian and New Zealand College of Ophthalmologists (RANZCO)

The Royal Australian and New Zealand College of Ophthalmologists (RANZCO) is responsible for the vocational training and continuing professional development of ophthalmologists in Australia and New Zealand. It is one of the smaller specialist medical colleges representing a workforce of approximately 1,200 ophthalmologists (Fellows) and 150 ophthalmology trainees.

RANZCO is accredited as a specialist medical college by the AMC and the MCNZ and, following the AMC's reassessment of RANZCO's training and education programs in October 2019, is accredited until March 2023.¹⁴³

As well as education and training, RANZCO advocates for the improvement of the quality and safety of care for patients and promoting eye healthcare in the community and reducing avoidable blindness in the Asia-Pacific region.

RANZCO's mission is to 'lead eye care by setting and improving standards, providing lifelong education, promoting research and innovation and advocating on behalf of patients, their communities and our membership.' The Strategic Goals under the RANZCO Strategic Plan 2022–23 are:

- **Education:** To be the preeminent provider of post-graduate eye health programs in our region.
- **Members:** To create an invaluable collegial Member experience through engagement and to develop Members who are ambassadors for RANZCO and the profession.
- **Advocacy:** To advocate for ophthalmology, the profession and world's best eye health for the community.
- **A Sustainable Future:** To ensure the sustainability of RANZCO and ophthalmology, and eye health in Australia and New Zealand.
- **Delivery:** To deliver outstanding organisational outcomes through continuous improvement of people and systems.

An Action under the Sustainable Future Strategic Goal is 'Workforce modelling and planning of new training posts to improve patient access to ophthalmologists', with the Measure of Success as 'A workforce model and plan that includes the establishment of additional training posts.'¹⁴⁴

143 AMC Accreditation Report: The Training and Education Programs of the Royal Australian and New Zealand College of Ophthalmologists, <https://www.amc.org.au/wp-content/uploads/2020/09/RANZCO-2016-19-Report-secured.pdf>

144 RANZCO Strategic Plan 2021–2023, https://ranzco.edu/wp-content/uploads/2020/10/RANZCO-Strategic-plan-2021_2023-FINAL.pdf



College Governance

RANZCO is a company limited by guarantee with charitable status and is governed by a Board of Directors. The Board comprises 11 Fellows of the College and its role is to make strategic decisions about RANZCO and to oversee the finances.

The Board is elected by the RANZCO Council, which has approximately 50 members drawn from the state and New Zealand branches, key internal committees, membership cohorts and external organisations. The Council provides strategic advice to the Board. Work undertaken for RANZCO by Fellows and members is provided on a voluntary basis.

The Board has an additional 40 committees that provide advice and materials to support work in education, training, continuing professional development, complaints, code of conduct, policy, advocacy, and international development.

RANZCO's Workforce Committee identifies and advises on existing and emerging eye health workforce issues. In 2019 and 2020, the Workforce Committee developed RANZCO's Workforce Survey, which was launched on 25 May 2020. Survey results informed strategy around selection, training, workforce modelling and advocacy to government across both Australia and New Zealand. The Workforce Committee also began planning for the implementation of a rural training post in 2019/20. Currently most training is undertaken in major cities and there is little scope for rurally based trainees to practice in a rural setting.¹⁴⁵

Accreditation Governance

RANZCO's Training Post Inspection Committee (also known as the Training Post Inspectorate) is responsible for overseeing the accreditation of training posts and approving the Final Accreditation Report, which is then sent for noting by RANZCO's governing body for education and training, the Qualification and Education Committee (QEC).¹⁴⁶ The Training Post Inspectorate meets twice a year and as required, in line with the QEC meetings. There is currently no formal rural representation on the Training Post Inspectorate.

Proposed changes to RANZCO's Standards for Ophthalmology Training Posts, against which applications for accreditation are assessed, must be approved by the QEC and adopted by the RANZCO Board.

¹⁴⁵ The Royal Australian and New Zealand College of Ophthalmologists Annual Report 19/20, <https://online.flippingbook.com/view/605674/>

¹⁴⁶ RANZCO Training Post Accreditation Policy, 30 November 2019, https://ranzco.edu/wp-content/uploads/2019/12/Training-Post-Accreditation-Policy_31.2019.11-03.pdf

Ophthalmology Specialty Training Program

The objective of RANZCO's Vocational Training Program (VTP) is to produce a specialist ophthalmologist who, on completion of training, is equipped to undertake safe, unsupervised, comprehensive, general ophthalmology practice. The VTP takes five years to complete and comprises the following stages:

- **Basic Training:** Two years of basic training during which trainees must demonstrate integrated clinical skills and knowledge in the Ophthalmic Sciences and the Ophthalmic Basic Competencies and Knowledge (OBCK). The OBCK examination is designed to assess the initial attainment of knowledge and skills in clinical ophthalmology.
- **Advanced Training:** Two years of advanced training during which trainees are expected to demonstrate integrated knowledge, clinical and surgical skills as documented in the clinical standards. At the completion of this term is the RANZCO Advanced Clinical Examination prior to the final or Fellowship year.
- **Final Year Training:** A final year during which the trainee develops their specialist experience in preparation for specialist qualification in the community as an independent general ophthalmologist.

On successful completion of the stages and the Censor-in-Chief's acceptance of the trainee's final year reports, graduates are eligible to apply for Fellowship of RANZCO (FRANZCO).

There are seven key role competencies adopted from the CanMEDS Framework which underpin selection, training and assessment:

- Ophthalmic expert and clinical decision maker
- Communicator
- Collaborator
- Manager/Leader
- Health Advocate
- Scholar
- Professional.

RANZCO's curriculum includes performance standards across the following eleven clinical areas of ophthalmology:

- Glaucoma
- Cornea
- Cataract and lens
- Neuro-ophthalmology
- Ocular inflammation
- Ocular motility
- Oculoplastics
- Clinical refraction
- Paediatric ophthalmology
- Vitreo retinal
- Refractive surgery

RANZCO's Annual Report 2018/19¹⁴⁷ reported an overhaul of the VTP curriculum, rolling out in 2021, to address shortages in ophthalmologists in regional Australia. One change that has already been implemented is a 5 per cent rurality (rural upbringing or work experience) score to the selection criteria. The Annual Report also outlined plans to revise the seven key role competencies to three:

- **Medical Expert:** ophthalmic knowledge and surgical expertise
- **Scholar**
- **Professional:** professional, collaborator, communicator, manager/leader and health advocate, culturally competent.

147 RANZCO Annual Report 18/19,
https://ranzco.edu/wp-content/uploads/2019/11/2018_2019-Annual-Report_low-res.pdf



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Supervision

Each training network has a Director of Training, each training site requires a Head of Department and each training post requires a minimum of three Clinical Tutors, including a Term Supervisor. For each additional trainee, there must be an additional consultant Clinical Tutor available.

A Clinical Tutor is defined as a RANZCO Fellow and a Term Supervisor as a Clinical Tutor who is a RANZCO Fellow who has been appointed by the training post and who coordinates the team of Clinical Tutors to provide education, training and work-based assessment of the trainees. It is the Term Supervisor who completes the trainee's End of Term Supervisors report in consultation with all others involved in the trainee's training.

On occasion, and subject to approval by the Regional QEC, a level of flexibility may be applied to supervision requirements, such as allowing one of the following to perform the role of Clinical Tutor:

- SIMG (surgical tutor only)
- RANZCO final year trainee (surgical tutor only)
- A consultant from another Australasian medical college.¹⁴⁸

Another example, provided by RANZCO, where flexibility has been applied, includes a waiver for an Alice Springs training post to have two Clinical Tutors rather than the required minimum of three. The complex cases seen at the Outreach Clinic in the rural Aboriginal communities provide an invaluable training experience for trainees that is not available in metropolitan settings, whilst still maintaining a safe training environment.

All clinical sessions undertaken by a trainee must be supervised by a Clinical Tutor. The Standards' definitions states that 'supervised' also includes 'overseen by a Clinical Tutor'. When a trainee is being supervised remotely, time must be allocated between the trainee and Clinical Tutor to discuss any issues from a clinic session.

Where a supervising consultant deems it unnecessary to closely supervise (Clinical Tutor present) a trainee in clinic, a trainee may be regarded as supervised provided there is at least one consultant within the building who is able to attend the clinic session if required. A trainee in the first two years of training must always be closely supervised when in theatre.

In relation to further supporting training in rural areas, RANZCO are undertaking further work to determine if there can be an extension of more supervision arrangements similar to Alice Springs with an ophthalmologist workforce that 'fly in' to provide a service. Another consideration is the extent to which telesupervision arrangements may be considered for senior / final year trainees.

Rotations

There are approximately 35 first year training positions in Australia and New Zealand in which training posts are located. Training posts are co-ordinated by training networks to provide continuous employment for the first four years in a variety of hospitals and other ophthalmic settings (training sites). The final year is more flexible for the trainee and is approved individually in advance.

It is the responsibility of the training networks to ensure that trainees receive supervised training and experience and assessment of the procedures according to RANZCO's curriculum standards in each of the clinical areas over the four years a trainee is in a training network.

148 RANZCO Standards for Ophthalmology Training Posts, 16 April 2018,
https://ranzco.edu/wp-content/uploads/2019/07/Standards_for_ophthalmology_training_posts.pdf

The seven training networks in Australia are the:

- Victoria Network
- Sydney Eye Hospital, NSW Network
- Prince of Wales Hospital, NSW Network
- Queensland Network
- South Australia Network
- Western Australia Network
- Tasmanian Network.

Each training network integrates a rural or regional rotation for trainees. For example, trainees in Sydney can rotate to Hobart, Broken Hill and Darwin.

Work is underway to establish an Australian Regionally Enhanced Training Network, with trainees in Years 1–4 undertaking 75% of training in a rural area.

All current networks include placements to regional and rural locations as part of the program (although this is not a specified requirement under the Standards for Ophthalmology Training Posts)¹⁴⁹. For example, the Sydney Eye Hospital network may include rotations to hospitals in Wagga Wagga, Darwin, Hobart and Lismore. The Prince of Wales Hospital network program is based at Prince of Wales Hospital with rotations to Sydney Children's Hospital, Sutherland Hospital, Broken Hill Base Hospital and the Outback Eye Service (including Bourke, Lightning Ridge, and others).

The Selection Committee of each of the training networks is solely responsible for employment decisions, including the training terms. The Queensland and South Australia training networks have six month rotations at sites whereas rotation terms may vary across the other networks. The Victoria training network is popular for providing the trainee's with an advance roster for their four years' training, allowing forward planning.

Accreditation Framework

RANZCO accredits training posts across Australia and New Zealand. As all training posts are part of a network, accreditation activities are network driven so that if one training post requires re-accreditation, RANZCO will schedule all training posts within the same network to undergo re-accreditation in order to maximise the time allocated by Inspection Teams. RANZCO's Training Post Inspection Committee, known as the Training Post Inspectorate, oversees the accreditation of training posts with accreditation being undertaken per training network.

At the time of this consultation, RANZCO had completed a review of the accreditation standards to align with best practice and changes in the clinical environment. There has also been the development and implementation of a policy to govern the process of accreditation.

RANZCO's VTP can only be undertaken in accredited training posts with potential training posts having to demonstrate that they meet the accreditation standards and that they provide optimised training opportunities and experiences before they are accredited.

Training posts for Years 1–4, Basic and Advanced training, are formally accredited by RANZCO and then the fifth or final year posts are approved by Censor-in-Chief on a case by case basis, based on the needs of the trainee.

Applications for accreditation are accepted at any time with the whole process of accreditation taking approximately six months. Training posts that comply with all the standards' criteria are accredited for three years.

149 RANZCO Training Network Information, <https://ranzco.edu/wp-content/uploads/2020/06/2020-Training-Network-Information-Revised-1JUN2020.pdf>



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Accreditation Standards

There are seven standards RANZCO use to assess training post accreditation applications. The standards and criteria are outlined in [Appendix 11](#) with further details on best practice and the minimum requirements for each criteria available in the *Standards for Ophthalmology Training Posts Includes: Code of Best Practice*.¹⁵⁰

The standards are broken down into criteria with mandatory and desirable requirements. RANZCO determined the absolute minimum equipment required to run a modern ophthalmology department, regardless of the location and identified the threshold. Desirable criteria are not required to achieve compliance with accreditation standards but can act as a stretch target for continuous improvement in ophthalmology specialty training.

RANZCO has articulated post specific factors that may require or allow specific adjustment to the way in which a particular post's compliance with the accreditation standards is assessed. These factors include:

- RANZCO is committed to Closing the Gap and the requisite cultural competence training that this requires. This includes encouraging exposure to both urban and remote Indigenous eye care.
- Some Training Posts will be suitable for a trainee in years one and two, but not for a trainee in years three and four, and vice versa; this will be outlined within the recommendation and recorded in the RANZCO database.
- A Training Post might offer surgical experience that would be satisfactory for a rotation period of three to four months, but not for a period of six months or longer.

There may be other factors that are to be taken into consideration. Each case to be assessed on its individual merits.¹⁵⁴

Accreditation Assessments

The Chief Inspector, assisted by the Training Post Inspectorate, is responsible for setting the Accreditation Schedule and The Inspection Team are responsible for conducting the inspection of the training posts' compliance with the standards.

RANZCO staff provide administrative support with matters related to applications for accreditation, including assisting with consulting the training posts on the scheduling of inspections to finalise the inspection timetable.

Assessments involve the inspection of all training locations within the training post (including all physical facilities and equipment), interviewing of trainees presently occupying training positions at the training post, and meeting with the Network Director, Head of Department, Supervisor of Training, Clinical Tutors, hospital administration and key training post medical administrative staff. RANZCO have developed a suite of standard questions for each stakeholder group the inspectors meet with during an accreditation inspection to improve consistency across accreditation teams and assessments.

Re-Accreditation Assessments

Site inspections of existing training posts take place on a three year cycle. Sites undergoing re-accreditation are provided six months' notice of the re-accreditation to prepare required documentation, data and information for the re-assessment against the accreditation standards. A component of the data required for accreditation assessments is logbook data. This is available to inspection teams to view for each trainee

150 RANZCO Standards for Ophthalmology Training Post, 16 April 2018, https://ranzco.edu/wp-content/uploads/2019/07/Standards_for_ophthalmology_training_posts.pdf

that is at a site in relation to trainee progress through the program, and if trainees are getting enough surgical exposure during their time in the training post.

Alternatively an inspection may be requested by an institution applying for a new training post, or the network QEC Chair because of changes in the network, such as changes in service delivery, infrastructure or a training position.

All accredited sites must demonstrate ongoing compliance with the standards and need to complete a policy certification statement on 31 January each year.¹⁵¹

Accreditation Teams

The Chief Inspector of the Training Post Inspectorate is responsible for determining the composition of Training Post Inspection Teams (including selection of the Senior Inspector). In the composition of inspection teams, factors considered include membership of the Training Post Inspectorate, FRANZCO, experience in accreditation, experience as a supervisor of specialty training, any COI and if inspectors have expertise or a special interest in rural, private, etc. The Chief Inspector ensures that both FRANZCO are from different jurisdictions to that being accredited to ensure an unbiased and balanced assessment.

The training post site visits are conducted by the Senior Inspector, an Inspector and a member of the RANZCO administration team. The Training Post Inspection Team makes an assessment against the accreditation standards and the Senior Inspector drafts the accreditation report with the inspection team. An Inspection Findings Notice is provided to the training post to review and provide a response back to the Senior Inspector, this may be in relation to factual corrections. The Senior Inspector amends the draft accreditation report, if appropriate, before submitting to the Training Post Inspectorate.

RANZCO does not currently conduct formal training for accreditation inspectors.

Accreditation Outcomes

The Training Post Inspectorate approves the Draft Accreditation Report. Once approved, the Final Accreditation Report is submitted to RANZCO's Quality and Education Committee for noting and a copy along with the outcome letter is forwarded by the Censor-in-Chief to the training post. Training posts that meet all the accreditation standards are accredited (unconditionally) for three years.

Temporary Accreditation

In times of unanticipated demand or circumstances that may arise, the Censor-in-Chief and Chief Inspector (the Temporary Accreditation Committee) may meet and determine to grant temporary accreditation to a training site for a specified duration and on specific terms.

The Training Post Inspectorate has the final decision on whether the Temporary Accreditation Committee's recommendation is accepted or rejected.

151 <https://ranzco.edu/home/ophthalmologists/training-post-accreditation/>



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Provisional Accreditation

For applications to establish new training posts, once they have been assessed as meeting the minimum mandatory requirements, usually one year provisional accreditation is awarded. In some cases, it could be two years as RANZCO will go back to the training post to inspect again. Once an assessment has been completed at the end of the provisional term and the training post has demonstrated that it satisfies all accreditation criteria, it will either progress to full accreditation or further recommendations will be made by the Training Post Inspectorate.

Conditional Accreditation

Where a training post demonstrates substantial compliance with the standards, but is not fully compliant, conditional accreditation may be recommended. The training post will be advised of the duration of the conditional accreditation and the conditions to be met prior to any interim inspections to determine full accreditation.

Adverse Reporting

Training posts must immediately advise RANZCO of any material change to training posts that may adversely impact the training post's capacity to continue to comply with the accreditation standards. The Chief Inspector, Censor-in-Chief and CEO may then decide:

- that no action is necessary
- conduct investigations
- put the accredited training post on notice of any required response or action
- request that the accredited training post show cause why its accreditation should not be suspended or revoked
- suspend accreditation pending further investigation.

Training Post Alert

RANZCO members who are of the belief that an accredited training post does not meet the accreditation standards and is a health or safety risk for the trainee must immediately lodge a written Training Post Alert with the RANZCO CEO. Any person who is not a member is also encouraged to lodge a Training Post Alert and may do so anonymously.

In addition to undertaking any of the above steps for adverse reporting, the Chief Inspector, Censor-in-Chief and CEO may choose to inform the accredited training post of some or all of the facts relating to the training post alert.

Suspension of Accreditation

The Chief Inspector and Censor-in-Chief, in consultation with the CEO, are responsible for determining suspension of accreditation.

The duration of the suspension will have the same effect as loss of accreditation. RANZCO will consult with the relevant stakeholders to ensure a limited negative impact to trainees and provide an opportunity for the accredited training post to address relevant concerns.

The training post will have no more than 12 months to meet the conditions set by the Training Post Inspectorate to qualify to have their suspension lifted. Failing this, the training post must reapply for accreditation. During the time of suspension, the training post is not accredited and cannot continue to participate in the training of RANZCO trainees or be eligible for trainee rotations into the training post.

Loss of Accreditation

An accredited training post will lose accreditation if it is unwilling or unable to demonstrate compliance with the Standards and the Chief Executive Officer and Censor-in-Chief believe conditional accreditation is not appropriate. A training post that has lost accreditation will no longer participate in the training or further rotations of RANZCO trainees and must reapply for accreditation.

Training posts must ensure that trainees continue to receive all relevant employment benefits during the period of any suspension or loss of accreditation.

Reassessment of Accreditation

Conditional accreditation, suspension of accreditation and loss of accreditation are subject to the College's reassessment under the Reconsideration, Review and Appeals Policy available on their website.¹⁵²

Accreditation Data Management

RANZCO's recently redeveloped IT platforms include a customised customer relationship management (CRM) database to capture accreditation information and improve automation and online interactivity. This platform is heavily customised for the needs of RANZCO and features the ability to pre-fill forms for accreditation, map ophthalmology training experiences, level of training, rotation length, FTE supervision, case mix and subspecialty training in the curriculum that can be covered at each accredited training post across Australia and New Zealand. The system also captures information on prior knowledge required or recommended to trainees before they go to that training post.

Each training post has a unique identifier within the system to ensure the correct management of data and history retention for each training post. The training post identifier is used by trainees in logbooks recording training experiences in each training post and supervisors use these identifiers for rotation pattern data. Accreditation data since 2005 has been integrated into the new system to ensure full accreditation history and the integrity of accreditation data reporting. The aim is for the system to also assist in rotation planning for supervisors and trainees to identify particular training posts against training requirements.

Information is collected both electronically and manually whilst the new IT platform functionality is developed.

¹⁵² RANZCO Reconsideration, Review and Appeals Policy, November 2018, https://ranzco.edu/wp-content/uploads/2018/11/Reconsideration-Review-and-Appeals-Policy_4.0-2.pdf



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Accreditation Review

The Accreditation Framework is reviewed biennially by RANZCO and its Quality and Education and Training Post Inspection Committees. Any proposed amendments to the standards developed by the Chief Inspector are presented to the Quality and Education Committee for consideration and approval prior to adoption by the Board.

The main drivers of change in the accreditation framework include curriculum changes, changes to the specialty training program, supervision requirements, regulatory changes such as the AMC, and government programs such as the STP. In addition to the review and refresh of accreditation standards and alignment with changes in the clinical environment, RANZCO explicitly ensured that the standards aligned with the 2015 AHMAC Accreditation Domains, Standards and Criteria developed for specialist medical colleges.

Other changes over the last two years have included minimum supervisor arrangements and minimum numbers of supervisors per trainee. With this requirement, a degree of flexibility is currently being considered by RANZCO in terms of supervision requirements in rural areas to further support the expansion of specialty training in these areas. The standards for accreditation have been improved to provide better guidance and understanding for health services to support and deliver high quality training. RANZCO has introduced requirements for a trainee wellbeing policy framework, which involves sites demonstrating evidence of policy and practice in relation to bullying, harassment, discrimination, complaints, safe work environment, including safe work hours and support for part time training and transition to and from extended periods of leave. RANZCO will also integrate a model for monitoring training posts and evaluating accreditation in the new IT platform.

Appendix I1: RANZCO Training Post Accreditation Standards and Criteria

RANZCO accreditation standards and criteria for ophthalmology training posts are provided below. Full details can be found on the RANZCO website.¹⁵³

RANZCO Vocational Training Program Accreditation Standards and Criteria

Standard 1 Site Facilities	
Criteria:	Requirements
1.1 There are facilities available in, or close to, the ophthalmic clinic or outpatients department. Please note: in children's hospitals, lasers may be located in the operating theatre.	1.1.1 Mandatory: <ul style="list-style-type: none"> • Fluorescein and other angiographies • Photocoagulation/Argon laser • NdYAG laser • Ultrasound: A scan • Ocular biometry (eg IOL master/Lenstar) • Automated visual field test • Internet access and computer facilities • OCT
	1.1.2 Desirable: <ul style="list-style-type: none"> • Contact lens fitting • Access to electrophysiology • Ultrasound: B scan • Access to ocular pathology • Corneal topography • Refractive laser • Emergency / Casualty
1.2 There are appropriate facilities available in the operating theatre.	1.2.1 Mandatory: <ul style="list-style-type: none"> • Operating microscope with assistant's scope • Camera, TV monitor and video recorder • Video facilities • Sufficient instrument trays • Phacoemulsification equipment • Vitrectomy equipment
	1.2.2 Desirable: <ul style="list-style-type: none"> • Dedicated theatre • Dedicated theatre staff • Cryosurgical equipment

¹⁵³ RANZCO Standards for Ophthalmology Training Posts, 16 April 2018, https://ranzco.edu/wp-content/uploads/2019/07/Standards_for_ophthalmology_training_posts.pdf



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Standard 2 Site Policy Framework

Criteria	Minimum Requirements
2.1 A policy framework is in place to cover the health, welfare and interests of the Trainees and to provide assistance to Trainees experiencing difficulty*.	2.1.1 Mandatory: <ul style="list-style-type: none"> • A policy framework including the following elements in order to promote the health, welfare and interests of the trainees and to provide assistance to trainees experiencing difficulty. Policies should include mechanisms to detect and respond to systemic issues impacting the health, welfare and interests of the trainees and include: <ul style="list-style-type: none"> • Bullying, Discrimination and Harassment Policy; • Complaints Policy; • Policy ensuring safe working environment including safe working hours; and • Policy supporting part-time training and transition into and returning from periods of extended leave.

* Training Posts that rely on public and tertiary hospital policy to meet this criterion must be able to provide evidence of formal adoption of relevant policy and confirmation that trainees have knowledge of and access to such policy. All accredited Training Posts shall be required to provide annual certification confirming compliance with this criterion.

Standard 3 Teaching and Learning Facilities

Criteria	Requirements
3.1 There are facilities and arrangements in place to support training.	3.1.1 Mandatory: <ul style="list-style-type: none"> • Teaching programs including didactic lectures, clinicopathological conferences and journal clubs • Exposure to clinical research methods e.g. clinical trials, case reports • Access to pathology and microbiology and biochemistry departments • Access to library of ophthalmic texts and journals in either print or electronic form and literature search facilities • A base location for trainees • Routine radiological investigations with access to CT & MRI scanning 3.1.2 Desirable: <ul style="list-style-type: none"> • Close liaison with other disciplines including neurology, neurosurgery, paediatrics, plastic and facio-maxillary surgery, endocrinology • Presentation and publishing of papers by trainees • Teleconference/video facilities for teaching lectures

Standard 3 Teaching and Learning Facilities

Criteria	Requirements
3.2 Each Training Post should have access to at least one microsurgical skills laboratory that is readily available to trainees within its Network.	3.2.1 Mandatory: The room must be of adequate size to contain: <ul style="list-style-type: none"> • At least one bench • One operating microscope with observer piece • Small refrigerator (not necessary if only nonanimal eyes are used) • Lockable cupboard for instruments, etc. • At least two and preferably three mobile chairs • Two or three people
	3.2.2 Mandatory: The room must have: <ul style="list-style-type: none"> • Good lighting • Adequate power points • Temperature control and/or ventilation
	3.2.3 Mandatory: Contents of the room must include: <ul style="list-style-type: none"> • Operating microscope as above • Chairs as above • Adequate instruments, sutures, viscoelastic, etc. • A log book for registration of session • Phaco machine • Suitable eye holder • Ideally a video with a monitor and video recorder

Standard 4 Supervision

Criteria	Requirements
4.1 Clinical Tutors and Term Supervisors	4.1.1 Mandatory: <ul style="list-style-type: none"> • A minimum of three (3) Clinical Tutors per Training Post including a Term Supervisor.
	4.1.2 Mandatory: <ul style="list-style-type: none"> • For each additional trainee, there must be an additional consultant Clinical Tutor available
	4.1.3 Mandatory: <ul style="list-style-type: none"> • Term Supervisor and Clinical Tutor commitment must be demonstrated by the time spent supervising the trainee. This is verified by a roster document and by trainee feedback. The full time equivalent participation of consultants must be sufficient to meet the RANZCO Standards for Supervision of Trainees (below).
4.2 Clinical Tutors are to be provided to the trainee	4.2.1 Mandatory: <ul style="list-style-type: none"> • Term Supervisors to provide appropriately qualified Clinical Tutors to the trainee



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Standard 4 Supervision

Criteria	Requirements
4.3 Term Supervisor Contact	<p>4.3.1 Mandatory:</p> <ul style="list-style-type: none"> Term Supervisors and trainees must have regular contact, weekly at a minimum
4.4 Supervised Clinical Sessions	<p>4.4.1 Mandatory:</p> <ul style="list-style-type: none"> All clinical sessions undertaken by trainees must be supervised by a Clinical Tutor. If a trainee does not need to be closely supervised in clinic, as assessed by the supervising consultant, a trainee may be regarded as supervised provided at least one consultant is present in the same building as the clinic and is available to attend the clinic at any time required by the trainee during the session. Supervision may be provided remotely. <p>4.4.2 Desirable:</p> <ul style="list-style-type: none"> A minimum of one (1) clinical session must be with the same person each week. <p>4.4.3 Mandatory:</p> <ul style="list-style-type: none"> A Clinical Tutor may not oversee more than three (3) trainees in a clinic session. <p>4.4.4 Mandatory:</p> <ul style="list-style-type: none"> Where remote supervision is provided, the trainee must be provided with a designated time to discuss any issues that may have arisen during the clinic.

Best Practice Guidelines

- The number of trainers associated with each trainee is a delicate balance. The minimum number of trainers is set out in this section, and this allows for reasonable breadth of exposure to different methods, preferences and teaching styles. On the other hand, too many trainers can be troublesome, as the trainees spend less time with each, and have more difficulty developing meaningful educational relationships with them.
- In Training Posts where there are a high number of potential trainers, it obviously makes most sense to preferentially use those who show the most commitment to teaching, and those who have the highest number of sessions in the department (to maximise both formal and informal trainee contact).
- In departments where final year trainees are also trained, there may be some benefit in separating College trainees from fellowship training to maintain a direct and undiluted trainee:trainer relationship. This is discussed further in the sections below.
- There is considerable benefit for the trainee in having frequent and consistent contact with most of their Clinical Tutors. At least one clinical session must be with the same person every week. Clinics which run on fortnightly cycles are less attractive, particularly as annual leave, holidays, etc. often reduce contact with a specific trainer even further.
- Clinics which occur once a month are highly undesirable, and should only be considered if there are compelling benefits visible, such as excellence in teaching or a rarity of case mix.

Standard 4 Supervision

Criteria	Requirements
4.5 Supervised theatre sessions	<p>4.5.1 Mandatory:</p> <ul style="list-style-type: none"> • All theatre sessions undertaken by trainees must be supervised by a Clinical Tutor. • A Clinical Tutor may not oversee more than two (2) trainees per operating session. • If a Clinical Tutor assesses that a trainee does not need to be closely supervised in theatre, that trainee may be considered to be appropriately supervised provided at least one Clinical Tutor is within the theatre complex, in theatre apparel, available to scrub and to attend theatre at any time during the session. <p>4.5.2 Mandatory:</p> <ul style="list-style-type: none"> • A trainee in the first two years of training must be closely supervised in order to: • ensure patient safety; • enable the Clinical Tutor to monitor the developing competence of the trainee; and • enable the Clinical Tutor to proactively identify any deficiencies in the trainee's performance as early as possible, and implement a suitable remediation process. <p>For the purpose of this requirement, "closely supervised" means a Clinical Tutor must be present in theatre.</p>

Best Practice Guideline:

- Surgical supervision occurring on a two-weekly rotation is necessarily much more disrupted, and four-weekly supervision virtually requires the trainee and Clinical Tutor to start afresh every time they meet so it is of limited value and highly undesirable.
- When supervision is more remote like this, there should still be a designated time for the trainee and the Clinical Tutor to discuss any issues that may have arisen during the surgery, such as a quick note review at the end of the clinic.
- It is very easy to stop training our trainees as soon as they become competent. Whilst a period of consolidation is valuable once trainees have acquired the basic skills, there is also a unique opportunity to take their expertise 'to the next level' by continuing close supervision, and discussing each case objectively.
- The RANZCO surgical assessment format is useful – what was done well, and should be continued; what should be done more; what should be done less. Encouraging trainees to participate in calm and objective critical analysis of their performance is of immense value.
- Increasing competence obviously gives the opportunity to expand the trainee's surgical exposure – either more complex cases, or procedures from Schedule 1, Table 2.



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Standard 5 Profile of Work

Criteria	Requirements
5.1 The Training Post provides a suitable workload and appropriate range of work	5.1.1 Mandatory The Training Post must provide each trainee with four (4) supervised clinics per week. A supervised clinic is one in which the trainee and the Clinical Tutor work with patients, either in tandem or in close proximity, to enable them to discuss cases and maximise training opportunities as they present.
	5.1.2 Mandatory The Training Post must provide each trainee with two (2) supervised operating theatre sessions per week. A supervised operating theatre session is one in which the trainee and the Clinical Tutor are present together in theatre, preferably without a fellow or another trainee present.
	5.1.3 Mandatory The trainee is provided with opportunities to be trained in and use lasers.
5.2 Supervised Clinics	5.2.1 Mandatory: Trainees and Clinical Tutors must work from the same patient list.
	5.2.2 Mandatory Term Supervisors at the commencement of a term, complete in conjunction with the trainee, an "Intentions for Term" document that will guide the Clinical Tutors as to what skills the trainee should achieve in the training post.

Best Practice guideline:

- There are many suitable models of supervision in clinic, but the ready availability of the Clinical Tutor is the key component.
- One Clinical Tutor may effectively supervise more than one trainee; two or three trainees is probably the practical limit – fewer if the trainer has their own clinic load to attend to.
- Fellows (such as visiting fellows or final year trainees) can supervise trainees in clinic, but it should be noted that, in this circumstance, the Clinical Tutor of the clinical session is required to be approved by RANZCO Regional QEC.
- There is great merit in supervised clinics working from one patient list, rather than the Clinical Tutor and the trainee having their separate patient lists. Benefits include:
 - the Clinical Tutor knows how many patients the trainee is seeing and how long they are taking – trainees should be rescued if a patient is taking much longer than normal;
 - the Clinical Tutor can select which patients the trainee should see – preferably selecting new patients, interesting clinical problems and patients the trainee has seen before (continuity of patient care is often sorely lacking through training); and
 - the Clinical Tutor may be able to give the trainee targeted assistance about what to look for in the allocated patient.
- Expectations regarding consultation about each patient with the Clinical Tutor should be explicitly defined early in the run. The art of presenting a patient to the Clinical Tutor is an extremely valuable one for the trainee (both in terms of preparation for exams and for practicing life). It also gives the Clinical Tutor an opportunity to understand and analyse the trainee's thought processes and their ability to sift through the noise and formulate sound structured management plans.
- It is not unreasonable to expect a first year trainee to report on every patient they see; more advanced trainees might only present new or complicated patients.

Standard 5 Profile of Work

Criteria	Requirements
5.3 Supervised Theatre Sessions	<p>5.3.1 Mandatory:</p> <p>The trainee implements procedures in accordance with a plan discussed beforehand with the Clinical Tutor taking into account the circumstances of each patient and the trainee's surgical skills (as previously demonstrated in a skills laboratory or on patients with a consultant in attendance).</p>

Best Practice guideline:

- At least one of the supervised surgical sessions each week should have direct trainee/Clinical Tutor interaction for the entire list, without any competing demands (final year trainees or visiting fellows, etc.).
- At least one of the supervised surgical sessions each week (preferably the same session as above) should have a case mix that is almost entirely suitable for the trainee's experience and skill level.
- The overall case mix should reflect RANZCO's lists of procedures (perform autonomously, assist with good knowledge, some understanding). Procedures that trainees are not necessarily expected to perform autonomously (Schedule 1, Tables 2 and 3) obviously provide an opportunity for the Term Supervisor or others (final year trainees or visiting fellows) to perform all or part of the surgery, but even these procedures may give some opportunity for the trainee to gain valuable skills by performing certain parts under supervision).
- It is important for at least one of the trainee's surgical sessions to be supervised by the same person each week, to allow development of surgical momentum. This issue is especially critical for junior trainees, whose confidence and skills may atrophy quickly without the opportunity to consolidate their skills by repetition.
- Surgical supervision occurring on a two-weekly rotation is necessarily much more disrupted, and four-weekly supervision virtually requires the trainee and Clinical Tutor to start afresh every time they meet so it is of limited value and highly undesirable.
- It is important that the trainee has continuity of care throughout the surgical episode. This includes the opportunity to assess the patient thoroughly pre-operatively (more than a quick look on the slit lamp in the surgical suite). The trainee should be able to enunciate and justify the surgical plan, identify particular areas of risk and plan contingencies.
- Trainees should be directly involved in the majority of their patients' post-operative care. Seeing their own cataract patients on day one will give them valuable feedback about what went right and what went wrong during surgery. Long term follow-up may be compromised by trainee rotations, but are also an essential part of the audit cycle.
- Alternating week rosters often make it more difficult for trainees to see their own patients post-operatively.



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Standard 6 Trainees' Surgical Experience

Criteria	Requirements
<p>6.1 Trainees' readiness for surgery</p> <p>To assist with adequate surgical exposure, it is strongly recommended that Accredited Training Posts are filled by 1st–4th year trainees, and not final year trainees.</p> <p>It is recommended that the trainee by the end of year two should have performed an adequate number of supervised intraocular procedures.</p>	<p>6.1.1 Mandatory:</p> <p>Term Supervisors must arrange for each new trainee to attend theatre as soon as practicable to become familiar with theatre business, technique, culture and protocols.</p> <p>Mandatory:</p> <p>Term Supervisors must as soon as practicable identify each trainee who has had no microsurgical experience and arrange a supervised program of wet lab or surgical simulator experience for the trainee.</p> <p>6.1.2 Mandatory:</p> <p>Term Supervisors must record a trainee's wet lab or surgical simulator experience and performance.</p> <p>Term Supervisors may use the College's <i>Theatre Performance Assessment</i> form for this purpose.</p> <p>6.1.3 Mandatory:</p> <p>The Term Supervisor must as soon as practicable make a judgment on the readiness of each trainee to perform procedures on patients and the degree of supervision required in theatre.</p> <p>6.1.4 Mandatory:</p> <p>A Term Supervisor of a term that is light in surgery should include in the 'Intentions for the Term' an arrangement for the trainee to maintain surgical skills in a wet lab or with a surgical simulator.</p> <p>6.1.5 Mandatory:</p> <p>Arrangements must be made as soon as practicable by the Director of Training for any trainee for whom there is a significant break in continuity of surgical exposure to regain such exposure and maintain surgical skills.</p> <p>6.1.6 Mandatory:</p> <p>Training Posts must ensure that priority is given to the surgical training needs of trainees.</p>

Standard 7 Trainees' Clinical Experience

Criteria	Requirements
7.1 Trainees' readiness for clinical work	7.1.1 Mandatory The trainee is to receive supervised training and experience, and be assessed according to the College's curriculum standards in each of the clinical areas.
	7.1.2 Mandatory The trainee is to be involved in a minimum of four (4) supervised outpatient clinics and two (2) supervised operating lists each week.
	7.1.3 Mandatory Trainees are to be involved in the management of ophthalmic casualties, probably by way of an emergency roster.
	7.1.4 Desirable Trainees should be involved in clinical audit, and in teaching at postgraduate and undergraduate levels where possible.



Appendix J: Royal Australian and New Zealand College of Psychiatrists (RANZCP)

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) is responsible for training, educating and representing psychiatrists in Australia and New Zealand.

RANZCP has over 6,900 members, including more than 5,100 fully qualified psychiatrists (consisting of both Fellows and Affiliates of the College) and 1,818 Associate members who are training to qualify as psychiatrists (also referred to as trainees).¹⁵⁴

In Australia, approximately 85% of practising psychiatrists are current RANZCP members. In New Zealand, more than 50% of practising psychiatrists are current members. In both countries, all psychiatrists must be accredited by the RANZCP before they can practise¹⁵⁵.

Within RANZCP, subspecialties and interest areas of psychiatric practice are represented by Faculties and Sections.

RANZCP consists of Branches in each state and territory of Australia as well as a Branch in New Zealand.

The RANZCP has a Section of Rural Psychiatry (SRP)¹⁵⁶ that promotes high standards in clinical practice, training and research pertaining to the practice of psychiatry in rural and remote locations. Some RANZCP committees have rural representation in their membership, committees will co-opt members with specific expertise or interests, as required. The SRP aims to:

- Promote the objectives of the College relating to rural and remote psychiatry.
- Advise on and advocate for training in rural and remote locations.
- Advance and disseminate research in rural and remote psychiatry.
- Contribute to and promote the highest standards of clinical practice.

The RANZCP is accredited by the AMC until March 2023.

154 <https://www.ranzcp.org/membership/about-membership>

155 <https://www.ranzcp.org/about-us/about-the-college>

156 <https://www.ranzcp.org/membership/faculties-sections-and-networks/rural-psychiatry-section>

College Governance

The Board is the governing body of RANZCP and consists of a minimum of seven Fellows of the College (FRANZCP), including the President and President-Elect. One Director must be from New Zealand and one Director must be from Australia with up to two additional Directors which may be appointed by the Board to fill identified skill gaps.

The Board is responsible for all matters relating to the strategic direction, policies, practices and the operations of the College.¹⁵⁷

The RANZCP *Strategic Plan 2018–2020*¹⁵⁸ identifies RANZCP's purposes and key priorities for the period. Delivery of the strategic plan is supported by an Operational Plan overseen by the Chief Executive and Executive Management team.

One of the purposes is to 'Improve the mental health of communities by working with stakeholders to support high quality psychiatric care'. Under this purpose the key priorities linked to medical workforce include:

- Engage and partner with governments, organisations and individuals to support high quality care.
- Support workforce planning, recruitment and retention to improve access to psychiatrists in private and public settings.

Committees of the Board include:

- Audit Committee
- Corporate Governance and Risk Committee
- Education Committee
- Finance Committee
- Membership Engagement Committee
- Practice, Policy and Partnerships Committee
- Members' Advisory Council
- Appeals Committee
- Membership Conduct Committee
- Overseas Trained Psychiatrists Representative Committee
- Trainee Representative Committee.

Branches are governed by Branch Committees who are responsible to the Board for the affairs of the Branch and the members within it. In the case of New Zealand, this is the New Zealand National Committee.

157 <https://www.ranzcp.org/about-us/governance/board>

158 The Royal Australian and New Zealand College of Psychiatrists, Strategic Plan 2018–2020, https://www.ranzcp.org/files/about_us/annual-reports-and-strategy/ranzcp-strategic-plan-2018-2020.aspx



Accreditation Governance

The Education Committee is a constituent committee that has responsibility for strategic education policy development and oversight of implementation and monitoring of education policy. The Education Committee reports to the Board on matters related to Fellowship and advanced certificate training and activities of its subcommittees. Subcommittees include the Accreditation Committee. The Education Committee meets face-to-face three times per year, and via teleconference or video conference options as required.

The Accreditation Committee (AC) has responsibility for the accreditation of psychiatry training programs and the Formal Education Courses (FECs). Recommendations and outcomes are developed and endorsed by the AC, and are progressed to the Education Committee and the Board for final approval.¹⁵⁹

The AC ensures transparency in the accreditation of rotations/runs and training programs through accreditation standards. The standards apply to the Fellowship training program, training rotations/runs, the formal education course, and the certificates of advanced training. The role of the AC includes:

- Establishing accreditation policy and procedures.
- Developing and maintaining accreditation standards.
- Selecting and appointing accreditation site visitors.
- Co-ordinating and scheduling accreditation visits.
- Reviewing site visit accreditation reports.
- Overseeing the implementation of recommendations in visit reports.¹⁶⁰

Although the RANZCP indicated during the consultation that accreditation visitor training is not occurring, the updated committee organisational chart dated April 2020 indicates that the AC oversees an 'Accreditation Visitor Training Working Group'.

Membership of the AC comprises of a Chair (Fellow), Deputy Chair (Fellow), Director of Training, Director of Advanced Training, Chair, Committee for Training (CFT) ex-officio (or nominee from the CFT), New Zealand representative, Trainee Representative Committee representative and Overseas Trained Psychiatrist representative.

The AC meets four times per year, two face-to-face meetings and two teleconference meetings.

The Branch Training Committees (BTCs) have responsibility for the accreditation of training posts. These committees report to the CFT, another subcommittee of the Education Committee.¹⁶¹

159 RANZCP, DOH Preliminary Online Survey Response – How Accreditation Practices Impact Building a Specialist Medical Workforce Consultation, 14 October 2019

160 <https://www.ranzcp.org/about-us/governance/committees/education-committee/accreditation-committee>

161 RANZCP, DOH Preliminary Online Survey Response – How Accreditation Practices Impact Building a Specialist Medical Workforce Consultation, 14 October 2019

Specialty Training Program

Stage 1 – Basic Level: 12 months at 1.0FTE Adult Psychiatry training in an accredited training post, either public or private facility with a key focus on core basic psychiatry skills. Six months must be in an acute facility.

Stage 2 – Proficient Level: 24 months at 1.0FTE in accredited training posts. There are two mandatory six month terms in the psychiatry qualification, Child and Adolescent Psychiatry and Consultation – Liaison.

The additional 12 months of FTE accredited training (out of the minimum 24 months FTE) must be undertaken in one or more of the following elective Areas of Practice, or in additional accredited training in Child and Adolescent Psychiatry and/or Consultation-Liaison Psychiatry:

- Addiction Psychiatry
- Adult Psychiatry
- Forensic Psychiatry
- Indigenous Psychiatry
- Psychiatry of Old Age
- Psychotherapies
- Research (a maximum of six months FTE may be undertaken in a research post. See below for further requirements of training in research).¹⁶²

Stage 3 – Advanced Level: Completion of a minimum of 24 months of 1.0 FTE training in accredited training posts. The training can be in any one or more of the following electives:

- Addiction Psychiatry
- Adult Psychiatry
- Child and Adolescent Psychiatry
- Consultation–Liaison Psychiatry
- Forensic Psychiatry
- Indigenous Psychiatry
- Psychiatry of Old Age
- Psychotherapies.

Specific supervision requirements are identified for each stage of training.

¹⁶² RANZCP Education Training Policy, Stage 2 Mandatory Requirements, <https://www.ranzcp.org/files/prefellowship/2012-fellowship-program/rpp/training/policy-%e2%80%93-stage-2-mandatory-requirements.aspx>



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Supervision

All supervisors of specialist training must participate in a training program to be accredited by RANZCP as a supervisor. All supervisors must be trained in the assessment of competencies as part of the training and are the responsibility of the local BTC. Supervisor training is usually two half days and delivered by each BTC.

A Principal Supervisor is the accredited clinical supervisor specified to oversee the supervision of a trainee in a particular training post.¹⁶³ Each training post must have a Principal Supervisor who works at least 0.3 FTE in the same clinical setting at the same time as a trainee and has no more than two trainees to supervise. Minimum supervision requirements are identified in the accreditation standards and also set per stage of the training program and supervisors will be accredited for Stage 1, Stage 2 and/or Stage 3 supervision.

RANZCP has Directors of Training (DOT) and Directors of Advanced Training. DOTs have a key role in accreditation, they have representation on the AC, the CFT, the BTC and the New Zealand Training Committee. Along with the relevant Branch Training Committee, they have responsibility for ensuring that training posts are accredited and continue to meet the accreditation standards.

When a training program is having its full accreditation visit (re-accreditation), the DOT is responsible for:

- Conducting an assessment of how the training program is meeting the accreditation standards.
- Ensuring that all necessary documentation and evidence is provided to the College for the use of the accreditation panel.
- Facilitating the arrangements for all meetings required by the accreditation panel, including any necessary teleconferencing with remote trainees and supervisors, and with relevant health service executive and management.
- Conducting tours of any facilities identified by the accreditation panel.
- Where they are directly responsible, ensuring that the recommendations of the accreditation panel, once approved by the EC and Board, are implemented.

When a training program is having a mid-cycle, desktop review, the DOT is responsible for conducting an assessment of how the training program is meeting the accreditation standards, and reporting on the progress of any recommendations from the previous accreditation visit.¹⁶⁴

Supervision can be provided by someone who is not a Fellow of the College such as an Affiliate member. It's more common in New Zealand because there are many more Affiliate members in New Zealand than in Australia because of the SIMG population. Affiliate members can supervise, as long as they are accredited to do so (as is the case for FRANZCP). Supervision can be provided by others who are not members of the College in some circumstances for some elements of the training program, such as psychotherapy Entrustable Professional Activities which can be signed off by psychologists.

RANZCP does support a model of remote supervision in cases where there are fly-in fly-out consultants. A model has been developed to ensure that in such situations, trainees are appropriately supervised and in accordance with accreditation standards.

163 RANZCP Education Training Policy and Procedure, Supervision, <https://www.ranzcp.org/files/prefellowship/2012-fellowship-program/rpp/training/policy-and-procedure-%e2%80%93-supervision.aspx>

164 RANZCP, DOH Preliminary Online Survey Response – How Accreditation Practices Impact Building a Specialist Medical Workforce Consultation, 14 October 2019

RANZCP also has refresher training courses for supervisors and supervisors must attend three peer review sessions per year to maintain accreditation as a supervisor. Re-accreditation for supervisors occurs every five years.

RANZCP has strict requirements in relation to ethics and conduct of supervisors and feedback on supervisor performance is sought from trainees by local BTCs and may be in the form of trainee surveys, end-of-rotation feedback or direct feedback.

Rotations

Each training rotation is six months throughout the training program. Rotational terms are determined by curriculum and training program requirements with allocation by the DOT in consultation with the local training committee. Progression of trainees through each rotation or term and trainee competency determines training rotations that are required. The training programs also determine rotational requirements, however, these are not built into accreditation recommendations.

Accreditation Framework

The RANZCP accredits specialist training programs and posts to ensure a quality education experience that facilitates the training of safe and competent psychiatrists. The accreditation of training programs are the responsibility of the AC. The RANZCP central office does not directly accredit health services or training posts, this is the responsibility of BTCs. There are 19 fellowship programs, in most instances, these are networks of health services (including private, public, community and not for profit services) in which posts have been accredited. Not all posts in a health service are accredited – many health services will have a mix of training registrars and service registrars. Each program has a DOT to oversee the program.

The AC re-accredits programs every five years and the BTCs re-accredit training posts every five years.

Any health service can apply for accreditation of a training post to the local BTC. Any post that is put forward for accreditation consideration must join one of the 19 fellowship training programs and meet the accreditation standards to be approved by the BTC or New Zealand Training Committee (NZTC).

Accreditation Standards and Criteria

There are Training Program Accreditation Standards¹⁶⁵ and Training Post Accreditation Standards,¹⁶⁶ both recently updated in November 2019. Both are outlined in Appendices [Appendix J1](#) and [Appendix J2](#), respectively.

165 RANZCP Accreditation of Training Programs, Training Program Accreditation Standards, November 2019, https://www.ranzcp.org/files/resources/assessor-supervisor/program-standards_final_20191009.aspx

166 RANZCP Accreditation of Training Posts, Training Post Accreditation Standards, April 2020, <https://www.ranzcp.org/files/resources/post-accreditation-standards.aspx>



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Accreditation Process

Health services can apply to accredit a training post at any time and must apply to the local BTC. Each new training post must join one of the fellowship training programs.

The BTC and DOT reviews the application via a desktop assessment to determine if it meets the Training Post Accreditation Standards. If the application meets accreditation standards, the BTC and DOT determines if it is necessary to establish an accreditation team to conduct a site visit assessment of the training post or if the application has satisfied all accreditation standards and does not require a site visit. The RANZCP does not prescribe an accreditation visit because often the local BTC will have some knowledge about a new post.

If a site visit is required, the accreditation team will meet with supervisors, trainees and health service executive (or management) as part of the assessment and may also undertake a visit of site facilities. During the assessment process, the accreditation team will validate the implementation of policies and support mechanisms for throughout through a review of evidence provided and interviews.

Once a training post has been accredited, the BTC advises the RANZCP training department and it gets put into the In-train system and becomes available for trainee allocation.

Training Program Accreditation

For training program accreditation (re-accreditation), there is a pre-visit questionnaire that must be completed by program management supported by data. There is a short formal survey of trainees which identifies both good practices and key areas of focus for accreditation visitors in relation to supporting specialty training. The accreditation panel will meet with key personnel involved in supporting the training program including the DOT, relevant supervisors, trainees and health service executive (or management).

When re-accrediting programs, RANZCP does not visit every site within the program. If through the feedback from the trainee surveys there is an area that is potentially a hotspot or there are issues identified, then RANZCP will visit particular sites to meet with supervisors and trainees.

Mid-Term Review

The mid-term review of a program is more complex and comprehensive. RANZCP will ask the Director of Training to self-assess the program against the standards and it also asks specifically about the implementation of any recommendations from the previous accreditation visit.

Trainees are requested to complete a different feedback survey to the formal re-accreditation survey to help to inform the progress of a program towards meeting accreditation standards.

Accreditation Outcomes

When an accreditation assessment is conducted, the accreditation team will consider if the training post or program has satisfied the respective accreditation standards. The accreditation report will rate the level of which has been achieved by the training post or program against each standard as 'Fully', 'Substantially', 'Partially', or 'Not Met'.

The accreditation reports are written by RANZCP staff, reviewed by members of the accreditation team, the Chair of the Accreditation Committee and another committee member before being returned to the DOT for fact checking. Once the report is returned, the accreditation recommendations are made to the AC, Education Committee and the Board.

Monitoring

Accredited training posts are monitored by the BTC using the RANZCP training management system, InTrain.

Accredited fellowship training programs are monitored by the AC via the College.

Should an accreditation issue be raised regarding an accredited training post, the BTC has delegated authority to address and manage the situation. However, the AC will monitor the situation and, if required, the CFT and AC will take action to provide support and remediate the situation.

The RANZCP ensures that trainee safety and welfare and by association, patient welfare and safety are paramount in considering the course of action required when issues arise. Remediation of issues is the preferred approach of RANZCP to try to ensure the continuity of training and support.

Significant issues can result in RANZCP disaccrediting a program including multiple failures of process and/or multiple failure to meet accreditation standards and not having a DOT or a training base.

Evaluation

RANZCP does not currently undertake evaluation of the accreditation process. There are regular trainee surveys that include feedback on the quality of supervision and training experience and feed into the accreditation assessment process.

Review

The RANZCP undertakes reviews of the accreditation framework as required, often when there are changes in curriculum, the training program and / or regulatory changes from the AMC.

The RANZCP reviewed all accreditation standards in November 2019 with a view to improving consistency, integrity, reporting and to make standards simpler to understand. RANZCP also actively sought to a more efficient and streamlined the process of reporting. RANZCP introduced a mid-cycle accreditation review which is a paper based, desktop review to monitor programs and training posts in an endeavour to identify any accreditation and training issues earlier.

There is other formal audit process, however RANZCP does engage in continuous improvement with BTCs and DOT, seeking consultation and feedback on a regular basis.



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Accreditation Changes over Time to Better Meet the Needs of Trainees and Support Health Services

RANZCP has introduced anonymous pre-accreditation visit surveys asking specifically what health services and training posts within the program the accreditation panel should physically visit has proven valuable in enabling trainees to speak up about issues. This has allowed accreditation panels to focus on areas of concern to trainees, particularly supervision, and welfare. During an accreditation visit the interview(s) with trainees are now scheduled first in the timetable so that the accreditation panel has the opportunity of exploring further with health service management, the DOT and supervisors any issues raised by trainees.

Standards have been revised over time to place greater emphasis on and clarity around the welfare of trainees. In addition, guidance documents for the interpretation of standards have been developed, one such example being the Adult Acute Inpatient Guideline.

The accreditation standards for training posts have been refined over the years, and BTCs have a range of processes to support health services with the provision of training. These processes vary, in line with the variation in health service structures throughout Australia and New Zealand, but include telephone support, support visits, and a reaccreditation timetable.¹⁶⁷

Accreditation Data Management

The RANZCP collects accreditation data manually and electronically. Some BTCs undertake the accreditation process via an online platform and conduct the accreditation process electronically. Some BTCs conduct a paper-based accreditation of training posts.

Electronically accreditation data of the training posts is captured in the RANZCP training management system, InTrain. The InTrain system records each accredited training post with a unique reference number so training post can be easily identified. Each training post has a supervisor or supervisors for that post allocated in the system.

If the accreditation date expires then there's a flag to remind RANZCP that accreditation is due to expire.

The accreditation of training programs are not recorded in the InTrain system. This is a manual process with records maintained in spreadsheet format that RANZCP is reviewing to improve with the recent changes to the accreditation standards to have better oversight of accreditation assessments.

¹⁶⁷ RANZCP, DOH Preliminary Online Survey Response – How Accreditation Practices Impact Building a Specialist Medical Workforce Consultation, 14 October 2019

Appendix J1: RANZCP Training Program Accreditation Standards

The Training Program Accreditation Standards for the accreditation of training programs are outlined below. Full details can be found on the RANZCP website.¹⁶⁸

Table 11 RANZCP Training Program Accreditation Standards:

Standard 1 Training Program Coordination	
1.1 Each training program has a BTC or, in New Zealand, the NZTC.	1.1.1 There is an appropriate number/range of trainee members of the BTC / NZTC for the size and complexity of the training program.
	1.1.2 There are members on the BTC / NZTC from local health services involved in the training program.
	1.1.3 The Chair of the BTC / NZTC is appointed by the Education Committee, from amongst the Fellows of the Branch / New Zealand, on the recommendation of the CFT, and the Branch Committee / New Zealand National Committee. The Chair is not normally the Director of Training.
	1.1.4 In larger programs, there are sub-committees, or working groups as required, to manage aspects of the program such as Psychotherapy. The CFT to be advised of any sub-committee or working group established by the BTC / NZTC.
	1.1.5 Regular meetings of the BTC / NZTC are held in accordance with RANZCP regulations, minutes recorded, and circulated to members. Conflicts of interest are declared to the Chair and recorded at BTC / NZTC meetings, as required.
1.2 Each program has a DOT formally recognised by the CFT.	1.2.1 There is a DOT formally endorsed by the BTC / NZTC, and recognised by the CFT, for each training program. The DOT is selected, appointed, and managed by the local health service.
	1.2.2 Including funded co-DOTs and local training coordinators, there is an adequate number of funded DOT sessions to meet the RANZCP minimum resourcing requirement, taking into account the size and complexity of the training program, and the expected roles of the DOT.
	1.2.3 The DOT role is consistent with the RANZCP Role Description and the DOT funding is consistent with the RANZCP minimum resourcing requirement.
	1.2.4 There are funded sessions for local Directors of Advanced Training that are appropriate to the size of the Advanced Training program. Additional DOT sessions are required if the DOT also covers aspects of Certificates of Advanced Training.

168 RANZCP Accreditation of Training Programs, Training Program Accreditation Standards, November 2019, https://www.ranzcp.org/files/resources/assessor-supervisor/program-standards_final_20191009.aspx



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Standard 1 Training Program Coordination

- | | | | |
|-----|--|-------|---|
| 1.3 | There are adequate administrative support and resourcing appropriate to the needs of the training program. | 1.3.1 | There is specifically funded administrative staffing reporting to the DOT to meet the RANZCP minimum resourcing requirement, taking into account the size and complexity of the program and the expected roles of administrative staff, especially if they organise the FEC and/or videoconferencing to rural/remote areas. |
| | | 1.3.2 | This administrative support is provided to assist in the administration of the training program. |
| | | 1.3.3 | There is a training base provided where administrative staff and the DOT are accessible to trainees, and where trainees have access to appropriate resources. |
| | | 1.3.4 | There is adequate resourcing as regards the office space, office supplies, work stations, and equipment required to run the program and training base. |

Standard 2 Provision of Required Training Experiences

- | | | | |
|-----|--|-------|---|
| 2.1 | A RANZCP-accredited FEC is available to trainees. | 2.1.1 | All FECs have formal accreditation via the AC. |
| | | 2.1.2 | There is assured access by trainees to an FEC. |
| | | 2.1.3 | BTCs and the NZTC are responsible for overseeing the FEC content and its delivery. |
| | | 2.1.4 | The BTC/NZTC has procedures for the monitoring of standards within the FEC, and has processes for monitoring and addressing issues within any FEC that is under its geographical jurisdiction. |
| | | 2.1.5 | There is adequate administrative support, facilities and equipment to ensure trainee access to the FEC, and to ensure the FEC delivery meets RANZCP requirements. |
| | | 2.1.6 | There are appropriate academic programs, or at least facilitation of individualised programs, for Advanced Certificate trainees wherever such posts exist locally. |
| 2.2 | The training program has an adequate capacity to train and provide a range of experiences. | 2.2.1 | The training program is able to provide the complete range of mandatory rotations and experiences. |
| | | 2.2.2 | Trainees in the program have access to a complete range of mandatory elements of Stage 1 and Stage 2 training so as to be able to achieve Fellowship after 60 months' FTE. |
| | | 2.2.3 | There are adequate processes to address any bottlenecks or inadequacies in access to training experiences. |
| | | 2.2.4 | The structure of the training program is determined with reference to the availability of supervised training posts, and the access to mandatory elements of training. |
| | | 2.2.5 | Satellite programs, e.g. in rural or provincial centres, which provide a more limited range of training experiences or rotations, are part of a larger accredited program and do not themselves provide stand-alone training. |

Standard 2 Provision of Required Training Experiences

2.3 There are adequate processes to ensure that training requirements are met within rotations.	2.3.1 Rotations facilitate a trainee's attainment of the associated Entrustable Professional Activities (EPAs).
	2.3.2 Processes are in place to identify and address any shortfalls in rotations, regarding their ability to provide the experiences necessary for a trainee.
	2.3.3 Supervisors and health service directors are aware of the specific training experiences required in any mandatory rotation to ensure that training posts in the health service provide them.
	2.3.4 Each rotation's ability to provide training experiences as set out in the training competencies for the rotation is monitored via the DOT / delegate at the six monthly meetings with trainees.
	2.3.5 Each rotation's ability to provide training experiences as set out in the training competencies for the rotation is monitored via the BTC / NZTC's accreditations of training posts.

Standard 3 Selecting, Monitoring and Supporting of Trainees

3.1 There are adequate processes for the selection of trainees into the training program.	3.1.1 There are adequate processes to attract and recruit applicants into the training program.
	3.1.2 Selection of new trainees into the program is based on the published selection criteria, as per the RANZCP selection process outlined in the Registration for Entry into Training regulation.
	3.1.3 There are adequate processes for convening and orientating selection panels, and for holding selection interviews.
	3.1.4 The composition of the selection panel is determined by the BTC / NZTC or delegated body, in consultation with the employing health services.
	3.1.5 The selection panel is chaired by the BTC / NZTC Chair or delegate.
	3.1.6 There should be trainee representation on the selection panel.
3.2 Here are adequate processes to monitor and manage the number of trainees within the program and an allocation process to ensure that placements are organised so that this Standard is met.	3.2.1 The training program maintains administrative records of trainees and of their placements for the use of the DOT and the BTC / NZTC in meeting their oversight responsibilities.
	3.2.2 The training program maintains a list of the program's trainees updated six-monthly, including their current work location, FTE and supervisors.
	3.2.3 There is an adequate process for the allocation of trainees to appropriate placements, according to their level of experience and to meet their training needs.
	3.2.4 There is close liaison with the employing health services regarding trainee placements and allocations.



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Standard 3 Selecting, Monitoring and Supporting of Trainees

3.3 There are adequate processes within the training program to support trainees.	<p>3.3.1 Advice is available to trainees to assist in accessing support.</p> <p>3.3.2 Pastoral care is available, including access to an EA, and formal or informal mentoring for trainees.</p> <p>3.3.3 Processes are in place to support trainees to meet assessment requirements, including access to pre-examination training programs, practice examinations, and assessment support.</p> <p>3.3.4 In larger training programs, the provision of local coordinators of training may be required to allow adequate support for trainees.</p> <p>3.3.5 There is assured access for all trainees to library services, institutional or library internet access, and office desktop access to the health service intranet.</p> <p>3.3.6 Trainees have the opportunity to work with allied non-medical professional staff who make significant contributions to the training experience of trainees.</p>
3.4 There are adequate processes to monitor the progress of trainees within the training program.	<p>3.4.1 There are adequate processes to monitor the performance of trainees, and to provide formal and informal feedback to trainees.</p> <p>3.4.2 Feedback and advice are provided to trainees regarding their progress in meeting training requirements.</p> <p>3.4.3 The RANZCP Targeted Learning Plans Policy and Procedure are followed, with records kept and submitted to the RANZCP Training Department of all formal targeted learning processes with trainees.</p> <p>3.4.4 Targeted learning that is rotation based, assessment based, or progression based as needed.</p> <p>3.4.5 These processes occur both within rotations and across changes between rotations. Specific progress reviews are organised as required.</p> <p>3.4.6 The RANZCP Failure to Progress, and RANZCP Progression through Training Policy and Procedure are followed, where applicable.</p>
3.5 There are robust processes within the training program to assess, monitor, promote, and deliver trainee welfare and well-being in the workplace.	<p>3.5.1 The workload for trainees within each post is such that clinical service delivery does not compromise training and trainee welfare.</p> <p>3.5.2 The working conditions for trainees within each post are conducive to training and trainee welfare.</p> <p>3.5.3 There are fatigue management programs, monitored by the DOT / deputy and reporting to the BTC / NZTC.</p> <p>3.5.4 Safe, secure and private amenities are provided for trainees required to work extended hours / overnight shifts.</p> <p>3.5.5 The atmosphere and morale within the training program are monitored by the DOT / deputy and the BTC / NZTC, and efforts are made to improve if problems develop.</p>

Standard 3 Selecting, Monitoring and Supporting of Trainees

3.6 RANZCP policies regarding trainee safety are followed within the employing service and the post.	3.6.1	There are systems and processes to maximise the safety of trainees and supervisors in the workplace. This includes afterhours policies, safe assessment areas, duress alarms, access to support and security staff, and training in the management of challenging behaviour.
	3.6.2	The BTC / NZTC and the DOT recognise that bullying of trainees is unacceptable, and ensure processes communicate that this is unacceptable and address this conduct promptly.
	3.6.3	Stage-specific orientation and guidance are available to trainees on avenues for raising training, safety, and welfare concerns.
	3.6.4	The employing service has policies for the support of any trainee involved in a critical incident, threatened or assaulted during their clinical work, and procedures to debrief trainees, and to review any such incident.

Standard 4 Standard of Training

4.1 There are adequate processes for quality assurance and evaluation of the training program, so that a good standard of training is provided.	4.1.1	The findings of any audits, reviews or accreditation visits are addressed so as to improve the training program.
	4.1.2	Prior RANZCP accreditation visit reports are reviewed by the BTC / NZTC, and the recommendations addressed and implemented.
	4.1.3	Reports from any interim program reviews by the BTC / NZTC are reviewed so that the recommendations can be evaluated and implemented by the BTC / NZTC.
	4.1.4	Aspects of any other audit such as an Australian Council of Healthcare Standards accreditation visit or any similar major review relevant to the training program are evaluated by the BTC / NZTC and recommendations are addressed.
	4.1.5	Outcome measures of the program are monitored by the BTC / NZTC and the DOT, such as trainees achieving Fellowship and pass rates for the Scholarly Project, the Psychotherapy Written Case, and centrally-administered examinations.
	4.1.6	The BTC / NZTC and the DOT are clear about the structure, objectives, organisation and content of the training program and the evaluation of trainees, and the accreditation of posts and supervisors.
4.2 A good standard of training is provided at all training posts within the program.	4.2.1	Clinical facilities provide the approved training and a suitable range of clinical experiences and elements of training.
	4.2.2	There is provision of local seminars, journal clubs, grand rounds, or group supervision.
	4.2.3	After-hours work is appropriately supervised and monitored.
	4.2.4	Psychiatrist staff provide clinical support to trainees, in addition to required supervision from approved supervisors.



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Standard 4 Standard of Training

4.3 There are adequate processes to monitor the standard of the training experience in all posts within the training program.	4.3.1	There are clearly documented processes to monitor the suitability of each post as a training experience, and to ensure that each rotation is adequately supervised.
	4.3.2	The DOT or delegate meets personally with trainees at least every six months to review their training progress and end-of-rotation ITAs.
	4.3.3	The DOT acknowledges, considers and, where appropriate, takes measures to address feedback received from trainees and RANZCP surveys.
	4.3.4	There are clearly documented processes to address any shortfalls in training posts regarding the provision of adequate training and supervision.
4.4 There are adequate processes to accredit/disaccredit training posts within the program.	4.4.1	There are administrative records of all training posts, regarding reviews, accreditation, or dis-accreditation processes.
	4.4.2	The program utilises the RANZCP Post Accreditation Standards to accredit posts.
	4.4.3	All posts are re-accredited at least every five years by the BTC / NZTC using the RANZCP Post Accreditation Standards.

Standard 5 Supervisors

5.1 There is adequate provision of supervision within the training program.	5.1.1	The training program maintains supervisor files with records of trained, accredited, and approved supervisors.
	5.1.2	The ratio of accredited supervisors to trainees is adequate. Wherever possible, supervision is by RANZCP Fellows.
	5.1.3	The ratio of RANZCP supervisors to accredited non-RANZCP supervisors is monitored by the training program.
	5.1.4	There is a maximum ratio of two trainees to one full-time supervisor.
	5.1.5	Trainees receive a minimum four hours of supervision each week for 40 weeks, as specified in the supervision policy: <ul style="list-style-type: none"> • A minimum of one hour of individual supervision of clinical work. • A minimum of three additional hours of supervision, either as an individual or in a group, which can include a clinical meeting where there is an education opportunity. • Minimum one hour of these additional three hours must be in a clinical setting where the focus is on the clinical supervision of the trainee.
	5.1.6	While this hour is required in full for all trainees, the other three hours of supervision per week must be on a pro-rata basis (minimum) for part-time trainees.
	5.1.7	Stage One trainees to receive closer supervision of two hours weekly of individual supervision of clinical work.
	5.1.8	Supervisors work alongside trainees at the same workplace for a minimum of three sessions weekly.
	5.1.9	The competency-based model of training is maintained.

Standard 5 Supervisors

5.2 There are good standards of training for supervisors within the training program.	<p>5.2.1 All supervisors complete RANZCP-accredited supervisor training initially (e.g. workshop) and thereafter a supervisor update training program every five years.</p> <p>5.2.2 RANZCP processes for the approval of non-RANZCP supervisors are followed.</p> <p>5.2.3 All accredited supervisors attend a supervisors' peer review session, or a general psychiatrists' meeting, where issues around supervision are discussed, a minimum of three times per year.</p> <p>5.2.4 Specific supervisory requirements for Stage Three trainees within different Sections or Faculties are followed where these have been approved by the A.</p> <p>5.2.5 All supervisors of the Psychotherapy Written Case must be accredited by the BTC / NZTC and be appropriately skilled and experienced to supervise psychotherapy.</p>
5.3 There are adequate processes to monitor the performance of supervisors within the training program.	<p>5.3.1 Adequate processes are in place to monitor the quality of supervision throughout the program via feedback from trainees.</p> <p>5.3.2 Supervisors receive feedback regarding their performance and their quality of supervision.</p> <p>5.3.3 There are adequate processes to improve the competency of unsatisfactory supervisors by providing training and upskilling.</p> <p>5.3.4 The BTC / NZTC has the ability to intervene rapidly to address any serious problems in the provision of supervision.</p>
5.4 There are adequate processes to support supervisors within the training program.	<p>5.4.1 Supervisors can contact the DOT / delegate, or BTC / NZTC for advice and support by phone or email.</p> <p>5.4.2 The DOT / delegate, or BTC / NZTC has regular meetings with all supervisors.</p> <p>5.4.3 The DOT ensures that relevant information circulated by the RANZCP regarding training is conveyed to all supervisors.</p> <p>5.4.4 Peer support is available to all supervisors.</p>



Appendix J2: RANZCP Training Post Accreditation Standards

The Training Post Accreditation Standards for the accreditation of training programs are outlined in below. Full details can be found on the RANZCP website.¹⁶⁹

Table 12 RANZCP Training Post Accreditation Standards

Standard 1 Service Requirements and Post Position Description		
1.1 Every post must have a position / job description.	1.1.1 Trainees are provided with a written position / job description for the post.	
	1.1.2 The position description details place of work, nature and quantity of clinical work (FTEs), times at work, and post category.	
1.2 A process is in place to monitor and review the trainee's work and case load.	1.2.1 Health services must have: <ul style="list-style-type: none"> • Processes to monitor and manage trainees' workload, and a policy on how concerns about excessive workloads are raised and addressed. • Processes and policies to address the trainee's and/or supervisor concerns about workload. • Processes and policies to assist trainees to manage clinical workloads. • After hours arrangements that don't compromise the intended training experience. 	
	1.3 Trainees must have orientation into the post.	1.3.1 Adequate orientation and introduction to the multi-disciplinary team must be provided by the supervisor and / or team leader. <ul style="list-style-type: none"> • Clear advice is provided to trainees including: • Communication policies and expectations for the rotation (clinical notes, referrals, discharge summaries). • Clinical responsibilities including multi-disciplinary team review meetings, and participation in handovers. • On-call / on-duty responsibilities. • Teaching responsibilities to house officers and medical students.
		1.3.2 Clear advice is provided to trainees including: <ul style="list-style-type: none"> • communication policies and expectations for the rotation (clinical notes, referrals, • discharge summaries), • clinical responsibilities including multi-disciplinary team review meetings, and • participation in handovers, • on-call / on-duty responsibilities, and • teaching responsibilities to house officers and medical students
		1.4 Trainees must have access to any generic and required health service training.

169 RANZCP Accreditation of Training Posts, Training Post Accreditation Standards, <https://www.ranzcp.org/files/resources/post-accreditation-standards.aspx>

Standard 1 Service Requirements and Post Position Description

1.5 The post must have adequate resources to enable trainees to take annual and study leave.	1.5.1	Trainees are able to take study and approved leave.
	1.5.2	Trainee is able to take up to four weeks of any approved leave during a rotation and, if approved by the BTC, up to six weeks.
	1.5.3	Leave cover arrangements should not compromise another trainee's training requirements.

Standard 2 Provision of Required Training Experiences

2.1 Where required, the post must allow for a trainee to be released from their post for FEC attendance.	2.1.1	Health services are required to provide assured access by trainees to an RANZCP accredited FEC for Stage 1 and Stage 2.
2.2 The post has an adequate capacity to train and provide a range of experiences.	2.2.1	The post must be able to provide all the required WBAs and EPAs appropriate to the nature of the term.

Standard 3 Selecting, Monitoring and Supporting of Trainees

3.1 There are adequate processes to support trainees in the post.	3.1.1	There are processes to support trainees to meet assessment requirements and pass examinations.
	3.1.2	There is provision of local seminars, journal clubs, grand rounds or group supervision.
	3.1.3	Trainees are provided with details of regular, scheduled clinical supervision sessions.
3.2 There are adequate processes to monitor and encourage the progress and training experience of trainees within the post.	3.2.1	There are adequate processes to monitor the performance of trainees and to provide formal and informal feedback, with specific progress reviews as required.
	3.2.2	Timely feedback and targeted learning processes must be in place for any underperforming trainees.
3.3 There are adequate processes at institutions or services that assess, monitor, promote, and deliver trainee safety, welfare, and well-being in the workplace.	3.3.1	The workload for trainees within each post is such that clinical service delivery does not compromise training and trainee welfare.
	3.3.2	Work rosters do not expose trainees to prolonged periods of duty, inadequate time off duty between work periods, inappropriate speed and direction of shift rosters, or irregular work schedules.
	3.3.3	Fatigue management programs are in place to diminish the impact of fatigue on the training experience for trainees within each post incorporating automatic mechanisms for sending trainees home after long night duty hours.



Appendices

Standard 3 Selecting, Monitoring and Supporting of Trainees

- | | |
|--|--|
| 3.4 RANZCP policies regarding trainee safety are followed in the post. | 3.4.1 Systems and processes exist to maximise supervisor and trainee safety, including afterhours policies, safe assessment areas, duress alarms, access to support and security staff, and training in the management of challenging behaviour. |
| | 3.4.2 Accreditation for a post to include after-hours work duties is conditional upon safe arrangements for ingress/egress to all likely sites of work. |
| | 3.4.3 Bullying and harassment of trainees is unacceptable and health services must ensure there are processes to communicate to other staff in the service that this is unacceptable, and to address this conduct promptly. |
| | 3.4.4 Safe, secure, and private facilities are provided for trainees required to work extended hours/overnight shifts. |
| | 3.4.5 The employing health service has policies and procedures to support any trainee involved in a critical incident or subjected to a threat or an assault during their clinical work, and to review such incidents. |

Standard 4 Institutions, Services and Training Posts

- | | |
|--|---|
| 4.1 There is an adequate standard of training and level of resourcing is provided to trainees. | 4.1.1 The post offers trainees adequate access to resources and supports for learning. |
| | 4.1.2 The trainee has assured access to basic psychiatry texts and a representative range of journals, library services, institutional or library internet access, and office desktop access to intranet. |
| | 4.1.3 The trainee has the opportunity, in the post, to work as part of a multi-disciplinary team. |
| 4.2 Adequate office or workplace facilities are available to the trainee. | 4.2.1 Services must provide adequate facilities for trainees to conduct their necessary clerical work and with internet and intranet access. These include access to office facilities for confidential interviews and psychotherapy with patients. |
| | 4.2.2 A personal office should be provided, however, where no personal offices are provided, the minimum requirement for each trainee is a desk, computer workstation, and lockable storage area for the trainee's texts and equipment, with access to a room for study or dictation. |
| | 4.2.3 Services must provide adequate facilities for trainees to conduct physical examinations or any appropriate medical care. |

Standard 4 Institutions, Services and Training Posts

4.3 Adequate processes ensure that specific training requirements are met within mandatory rotations.	4.3.1	For Stage 1, 2 and 3 trainees all required WBAs and EPAs for the rotation as per the 2012 Fellowship Regulations are available.
	4.3.2	All Stage 1 posts must provide a good grounding in core clinical skills.
	4.3.3	All Consultation-Liaison training posts within rotations must: <ul style="list-style-type: none"> • Provide a liaison component as well as the consultation experience. • Ensure that trainees spend no more than 30% of their time in the ED.
	4.3.4	Trainees in Child and Adolescent Psychiatry training posts: <ul style="list-style-type: none"> • Are engaged in the care of, including adequate exposure to, both pre-pubescent and adolescent patients. • If caring for patients older than 18 years of age, spend a minimum of 80 per cent of their time engaged in the care of patients aged 0–18 years. • Do not spend more than a maximum of 20% of their time during standard work hours seeing child and adolescent patients in an ED.

Standard 5 Supervision

5.1 There is adequate provision of supervision within the post	5.1.1	Trainees are able to achieve the requirement for mutually observed interviews and assessments (trainee observing supervisor and supervisor observing trainee).
	5.1.2	Trainees receive a minimum four hours of 1:1 supervision each week for 40 weeks, of this two hours/week outside ward rounds and case review and minimum one hour individual supervision of clinical work. While this hour is required in full for all trainees, the other three hours of supervision per week must be on a pro-rata basis (minimum) for part-time trainees. First year trainees to receive closer supervision of two hours/week outside ward meetings. Supervisors work alongside trainees in the workplace for a minimum three sessions weekly. There is a maximum ratio of one full-time supervisor to two trainees. There should be access to clinical oversight at all times.
	5.1.3	In-Training Assessments are completed by supervisors at mid-rotation and end-of-rotation.
	5.1.4	Accredited supervisors are competent in the elements of the Fellowship Program and facilitate the required WBAs and EPAs for trainees in the rotation.
5.2 There are adequate standards of training and accreditation for supervisors within the post.	5.2.1	Supervisors must complete RANZCP-accredited supervisor training initially and, thereafter, a supervisor update training program every five years.
	5.2.2	Accredited supervisors must have access to and be able to demonstrate familiarity with the RANZCP Fellowship Regulations 2012, the RANZCP Curriculum Map and Syllabus, and the RANZCP Code of Ethics.
	5.2.3	Accredited supervisors are able to attend supervisors' peer review sessions, or a meeting of psychiatrists where supervision is the focus, a minimum of three times per year.
	5.2.4	Non-RANZCP supervisors, who are not Fellows, must complete RANZCP-approval processes.



Appendix K: Royal Australian and New Zealand College of Radiologists (RANZCR)

Founded in 1935, the Royal Australian and New Zealand College of Radiologists (RANZCR) is a not-for-profit professional organisation for clinical radiologists and radiation oncologists in Australia, New Zealand and Singapore.

RANZCR administers training programs for admission into the clinical radiology and radiation oncology professions, accreditation for overseas-trained specialists, and a continuing professional development program for members. Through policy, advocacy, quality and standards and research activities, RANZCR works with members to promote the science and practice of clinical radiology, and radiation oncology.

RANZCR is a membership organisation led by clinicians who are democratically elected by the membership, with oversight from a Board of Directors. RANZCR has local branches in New Zealand, each state of Australia and the Australian Capital Territory.

RANZCR represents 4,486 Fellows across Australia and New Zealand. RANZCR encompasses two Faculties: the Faculty of Clinical Radiology which has 3,785 members and the Faculty of Radiation Oncology which has 698 members.

RANZCR is accredited by the AMC until 31 March 2024.

College Governance

RANZCR is a clinician led organisation and the Board of Directors is the overarching governing body. The Board has responsibility and oversight of:

- Determining the RANZCR mission, purpose and strategic priorities
- Ensuring legal and ethical integrity
- Ensuring effective planning and performance
- Strengthening programs and services
- Ensuring effective communication with members
- Ensuring adequate resources, protecting assets and providing proper financial oversight
- Enhancing the College's public standing
- Selecting, supporting and evaluating the Chief Executive Officer.¹⁷⁰

RANZCR's structure includes the Faculty of Clinical Radiology¹⁷¹ and Faculty of Radiation Oncology.¹⁷² These Faculties are governed by Councils, which oversee all bodies within each Faculty responsible for overseeing training, professional standards and the advancement of knowledge in their respective professions.

170 <https://www.ranzcr.com/college/about/structure-governance>

171 <https://www.ranzcr.com/our-professions/faculty-of-clinical-radiology>

172 <https://www.ranzcr.com/our-professions/faculty-of-radiation-oncology>

RANZCR's structure also includes Branches in every state of Australia, the ACT, and New Zealand whose purpose is to:

- Facilitate communication with and between members and develop opportunities for discussion and continuing professional development.
- Represent the professional, educational and political interests of clinical radiologists and radiation oncologists at all levels within the Branch.
- Provide a conduit of information to and from Branch members with the College Board via the elected Councilors.¹⁷³

Committees are dedicated to specific areas of RANZCR's operations.¹⁷⁴ There are committees within each Faculty and some that are college-wide. Within each faculty, there are also working groups, reference groups and panels.

The RANZCR *Strategic Plan 2022–2024* has six main priorities, Member Experience, Advocacy, Education, Workforce, Clinical Excellence and Organisational Resilience. The *Education* priority is to 'Design, deliver, and quality assure global best practice training and continuing professional development programs to ensure our members are competent, current, and culturally safe.' There are four goals identified:

- **Goal 3.1:** Complete reforms to training programs so that they lead international best practice.
- **Goal 3.2:** Active and targeted support of trainees and supervisors.
- **Goal 3.3:** Build and maintain a sustainable and fit-for-purpose infrastructure to support our training and assessment activities
- **Goal 3.4:** Provide first rate post-Fellowship development support

Key initiatives to achieve these goals include, but not limited to, reform in training and assessment, professional development for supervisors, flexibility and wellbeing, and training networks.

The *Workforce* priority is to 'attract, select and train a workforce that is flexible and adaptable to the evolving needs of healthcare systems, and representative of the populations of Australia and New Zealand'. There are three goals, two of these goals relate directly to distribution and growth of workforce. Key initiatives are also identified to achieve these goals.

- **Goal 4.1:** Enable a workforce that is diverse, representative, sustainable, and appropriately distributed.
- **Goal 4.2:** Deliver effective infrastructure, funding and College processes to grow the workforce.

Key initiatives to achieve these goals include, but not limited to workforce planning, support mechanisms for specialist in regional areas, attracting Maori and Aboriginal and Torres Strait Islander doctors into the professions, training site accreditation update, and partner with governments.¹⁷⁵

173 <https://www.ranzcr.com/college/branches>

174 <https://www.ranzcr.com/college/committees>

175 The Royal Australian and New Zealand College of Radiologists, Strategic Plan 2022–2024, <https://www.ranzcr.com/search/ranzcr-strategic-plan-2022-2024>



Accreditation Governance

The Faculty of Clinical Radiology and Faculty of Radiation Oncology have overall responsibility and ownership for the accreditation framework and functions.

The Clinical Radiology Education and Training Committee (CRETC)¹⁷⁶ and Radiation Oncology Education and Training Committee (ROETC)¹⁷⁷ are each responsible for oversight and monitoring of the accreditation processes for their respective faculties.

Clinical leads known as Chief Accreditation Officers (CAO) are appointed to oversee the accreditation program in both Faculties. A deputy CAO position was established in 2018 in Radiation Oncology. Due to increased workload in monitoring training site accreditation and the increasing number of training sites, the CRETC established a Clinical Radiology Training Accreditation Working Group (CRTAWG) to become a subcommittee of the CRETC. The Working Group will appoint a deputy CAO and have a variety of objectives around training accreditation.

RANZCR appointed an accredited systems auditor in 2018 as the Senior Project Officer to support the operations of the training site accreditation programs.¹⁷⁸

RANZCR evaluates new and current training sites against those accreditation standards, which have been accepted by the Faculties of Clinical Radiology and Radiation Oncology.

Clinical Radiology and Radiation Oncology Specialty Training Programs

The RANZCR Radiation Oncology Training Program is a five-year program in two phases:

- Phase 1 (36 months)
- Phase 2 (24 months).

The Figure 1 below outlines the Radiation Oncology Training Program structure.

The RANZCR Clinical Radiology training program is also a five-year program in two phases:

- Phase 1 (3 years): General radiology training
- Phase 2 (2 years): Systems-focused rotations for advanced radiology training.

Training for both programs is undertaken through accredited network training sites. Trainees rotate to a number of training sites throughout their training.

Figure 2 below outlines the training program and the type of assessments for Clinical Radiology.

176 Clinical Radiology Education and Training Committee Terms of Reference, <https://www.ranzcr.com/search/clinical-radiology-education-and-training-committee-terms-of-reference>

177 Radiation Oncology Education and Training Committee Terms of Reference, <https://www.ranzcr.com/search/radiation-oncology-education-and-training-committee-terms-of-reference>

178 RANZCR Preliminary DOH Online Survey Response, October 2019

Figure 1 FRANZCR Radiation Oncology Training Program Structure¹⁷⁹

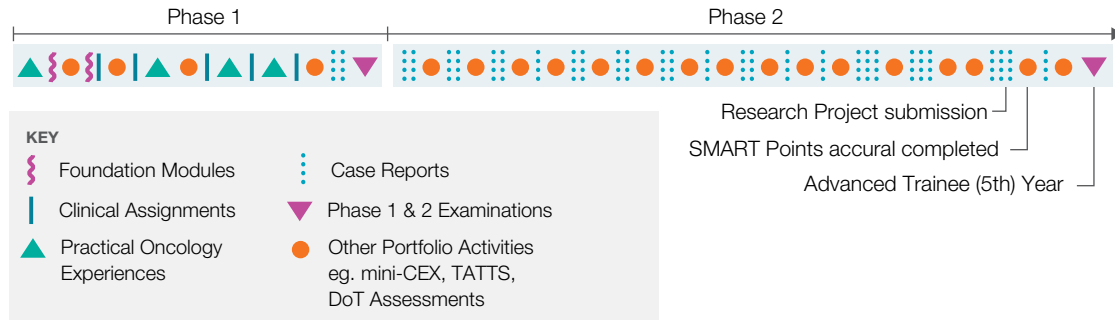


Figure 2 FRANZCR Radiodiagnosis Training Program¹⁸⁰

	Year 1	Year 2	Year 3	Year 4	Year 5	Post-training
Learning Components	AIT, Anatomy Key Conditions Report Writing Patient Safety	Radiodiagnosis Pathology Audit Skills EBM in Radiology Project 1	Radiodiagnosis Pathology Presentation Skills Project 1 Ethics & Research	Exam Tutorials Ethics & Research Project 2	Management Skills Project 2	Advanced Learning CME & CPD
Experiential Training	Basic modalities 1st Year US training X-Rays Emergency Radiology	Basic Modalities Some Systems Exposure VIR, Pediatric Breast, NM, O&G		System-focused Rotations 4 x 3 months	System-focused Rotations 4 x 3 months or 2 x 6 months or NM Year 1	Subspecialty Fellowship, NM Training or Research
Assessment	Part 1 Exam			Part 2 Exam		
	DoT 6-monthly assessment US logbook DOPS x 2 IPX x 2 MSF x 1	DoT 6-monthly assessment DOPS x 2 IPX x 2 CAT x 2 MSF x 1	DoT 6-monthly assessment DOPS x 2 IPX x 2 CAT x 2 MSF x 1 Project 1	DoT 6-monthly assessment DOPS x 2 IPX x 2 MSF x 1	DoT 6-monthly assessment VIR logbook DOPS x 4 MSF x 1 Portfolio 2 Project 2	FRANZCR awarded
Assessment Barriers	◆ ◆	◆ ◆		● ● ● ●	● ● ● ●	
	◆ Part 1 Exam Non-barrier Anatomy + AIT	◆ Part 1 Exam Barrier Anatomy + AIT	◆ Training Progression Barrier	● Part 2 Exam Non-barrier RD + Path	● Part 2 Exam Barrier RD + Path	

Abbreviations: AIT: Advanced Imaging Technology • CAT: Critically Appraised Topics • CME: Continuing Medical Education
 • CPD: Continuing Professional Development • EBM: Evidence-based Medicine • DOPS: Directly Observed Procedures
 • IPX: Individual Patient Examination • MSF: Multisource Feedback • NM: Nuclear Medicine • RD: Radiodiagnosis

179 RANZCR Radiation Oncology Training Program Curriculum, <https://www.ranzcr.com/documents/4369-radiation-oncology-training-program-curriculum/file>

180 RANZCR Radiodiagnosis Training Program Curriculum V2, <https://www.ranzcr.com/documents/159-radiodiagnosis-training-program-structure/file>



Appendices

Providing a training environment that is supportive of trainee needs and meets the training curriculum and regulatory requirements is a shared responsibility of RANZCR, training departments, training networks, clinical supervisors and trainees.

All RANZCR trainees in Australia, New Zealand and Singapore are trained within an accredited hospital department or private practice.

Trainees are expected to meet milestones in each year of the training program. These include assessment projects, exams, logbooks and other forms of assessment.

Supervision

Registrars must conduct their duties under the supervision of a consultant radiologist or radiation oncologist. For radiation oncology the departmental roster must clearly indicate the Clinical Supervisor (CS) on a daily basis. RANZCR recommends that all clinical radiology trainees have all reports reviewed by a supervising radiologist and ideally are supervised face to face, allowing for jurisdictional differences.

The degree of supervision may vary depending on the experience and level of training of the registrar. As more experience and seniority is achieved, registrars may report in a more independent fashion, as determined by the CS.

A CS may only be accredited when they are a:

- Fellow of the RANZCR (FRANZCR) or Educational Affiliate who has been granted full specialist recognition as a radiologist by means of entry into the specialist register or other category as deemed appropriate by the relevant state or territory medical board.
- Fellow of another Australia/New Zealand College in the case of specific sub-specialty training.

The supervision requirements vary, to the different levels for competency.

Network Training

RANZCR introduced a network-based system of training with the introduction of the new training program curriculum for radiation oncology trainees in 2008/09 and in 2009/2010 for clinical radiology.

'The focus within medical specialist training, driven by the AMC, is to encompass multiple sites or 'networked' training. A single site training program is increasingly less able to provide the comprehensive experience required to reflect the varied workplace scenarios within the modern health care system, with its mix of public and private services, and metropolitan and rural locations. Training networks place increased emphasis on competencies, utilising multidisciplinary teams and recognising that trainees within a network training program receive a broader range of learning experiences to equip them for the specialist workforce.

Training networks in both Faculties address the need for increased capacity to train by encompassing new training sites, which may have the advantage of adding an increased variety of training experiences (e.g. rural, private sector and sub-specialty). Trainees gain a broader training experience by working with different consultants and other health professionals in a variety of settings, and by seeing a more diverse group of patients or casemix. It is envisaged that this variety of experiences will contribute to the network's ability to deliver comprehensive training and fulfil RANZCR curriculum requirements¹⁸¹

181 RANZCR Clinical Radiology Network Training Policy,
<https://www.ranzcr.com/search/clinical-radiology-network-training-policy>

The *Radiology Network Training Policy*¹⁸² and the *Radiation Oncology Network Training Policy*¹⁸³ set out the governance arrangements and framework required to support a networked training program for each faculty. The policies provide the definition, intentions, key elements of a training network and the elements for the physical and training environments, the accreditation for network training and the governance and reporting structures and requirements.

For each faculty a training network is a formalised system of training delivery, whereby:

- Training sites are linked for the purpose of delivering the Faculty's Training Program Curriculum.
- Trainees gain access to multiple facilities for each faculty that offer different settings, senior staff and patient groups and for clinical oncology different tumour sites.
- Trainees gain access to all experiences required to fulfil the faculties' curriculum and training program requirements.

The Radiation Oncology Faculty governance structure consists of a Network Governance Committee for each network. They report to RANZCR's Radiation Oncology Education and Training Committee. There is also the Training Network Directors Committee. Its objectives are to:

- Provide an opportunity for discussion of ideas and strategies to improve training and recruitment within networks
- Provide review, feedback and recommendations to the Radiation Oncology Education and Training Committee regarding:
 - networked training
 - implementation of the curriculum
 - redesign of the training program to meet the requirements of the Network Training Policy and the training program curriculum.¹⁸⁷

The Clinical Radiology Faculty allows for smaller networks call Local Area Networks (LAN) which will be part of a Wider Area Network (WAN). Each LAN has a Local Governance Committee (LGC). Each WAN will have a Network Governance Committee (NGC). Issues that cannot be resolved by the LGC are considered by the NGC. Issues that cannot be resolved and are relevant to site accreditation, training program, assessments or trainee progression and other College-related issues have to be escalated onto the CRETC.¹⁸⁴

For Clinical Radiology each network must have a Network Training Director (NTD) and at least one DOT at each site. Radiation Oncology must have a Training Network Director (TND) and at least one DOT at each site.

To function effectively, each network for both faculties should have an Education Support Officer (ESO) to support training administration. The network is responsible for sourcing funding for the ESO.

182 RANZCR Clinical Radiology Network Training Policy,
<https://www.ranzcr.com/documents/3313-radiology-network-training-policy/file>

183 RANZCR Faculty of Radiation Oncology, Network Training Policy Document,
<https://www.ranzcr.com/documents/700-faculty-of-radiation-oncology-network-training-policy/file>

184 RANZCR Clinical Radiology Network Training Policy,
<https://www.ranzcr.com/documents/3313-radiology-network-training-policy/file>



Appendices

Rotations

As part of the network training program each trainee is allocated to a network and will be required to rotate within the network over the course of their training with rotations. Clinical radiology rotations being at least three to six months in duration and 12 months in radiation oncology. The Faculties' network training policies detail the requirements for the rotations. They include that trainee rotations must be prospectively planned, requiring at least six months' notice. For clinical radiology each network will include at least one private rotation and one regional or remote location.

The radiation oncology policy expects a fair and equitable distribution of trainee rotations is followed, especially with respect to rural and smaller sites where senior trainees (Year 3, 4, 5) are expected to rotate where possible.¹⁸⁵

Training rotations are determined by the LGC or NGC, which are chaired by the NTD in Clinical Radiology or TND in Radiation Oncology.

Accreditation Framework

The two faculties have different accreditation standards:

1. The *Faculty of Radiation Oncology: Accreditation Standards and Criteria for Training Networks and Sites*.¹⁸⁶
2. The *Accreditation Standards for Education, Training and Supervision of Clinical Radiology Trainees*.

Clinical Radiology and Radiation Oncology Accreditation Standards

The accreditation standards for radiation oncology apply for the network arrangement ([Appendix K1](#)) and then for the network training site ([Appendix K2](#)).

Clinical Radiology Standards and Goals

The accreditation standards consist of three main goals:

- **Goal 1:** The Training Sites Promotes the Welfare and Interest of Trainees.
- **Goal 2:** The Training Site ensures Clinical Radiology trainees have the appropriate knowledge, skills and supervision to provide quality patient care.
- **Goal 3:** The Training Site provides a wide range of educational and training opportunities for trainees that are aligned with the requirements of the Radiodiagnosis Training Program Curriculum. (Sites are expected to see trainees through the full five year program, subject to trainees satisfying the required training milestones).

The goals are broken down into standards and criterion within those. The clinical radiology accreditation standards are currently under review and network accreditation standards are being developed.¹⁸⁷ Details of the clinical radiology accreditation standards can be found at [Appendix K3](#).

185 <https://www.ranzcr.com/college/about/structure-governance>

186 RANZCR Radiation Oncology Accreditation Standards and Criteria for Training Networks and Sites, <https://www.ranzcr.com/search/radiation-oncology-accreditation-standards-and-criteria-for-training-networks-and-sites>

187 RANZCR Interview with DOH transcript, 4 December 2019

Accreditation Panels

Accreditation panels are used to conduct site visits. Membership of the panel is by completion of an Expression of Interest (EOI). The EOI is considered by the relevant committee and by the Chief Accreditation Officer. Accreditation panels consist of the CAO, other members and in clinical radiology, a Branch Education Officer (BEO).

Clinical Radiology

Hospitals and practices seeking to become a training site for clinical radiology are required to join the most relevant training network, based on geography or training experiences available. Interested sites are directed to the most appropriate NTD for assistance and advice.

New sites must complete the Application for Full/Linked site accreditation by completing a Site Self Assessment Form to apply as a clinical radiology training site and supply the supporting documentation. The application is considered by the relevant CAO via desktop review. If required a site visit will be organised. The assessment visit is completed by the CAO or delegate with an accreditation panel including clinical radiologist and College support staff. The visit agenda includes meetings with the Director of Training, Director of Department, consultants and health service management and executive staff.

Following the visit or assessment the CAO provides a confidential preliminary report of the visit to the BEO, the DOT and Director of Department (DOD) for review.

Once the report has been agreed, the CAO presents the preliminary report and recommendations to the CRTAWG at its next meeting. The CRTAWG will make recommendations at the next CRETC meeting. The CRETC reviews the report, considers the recommendations and either approves or amends the recommendation. The decision is communicated to the applying site by outcome letter, which includes the NTD and BEO.

The CRETC provides the site with an assessment rating. It may provide a 12 month provisional period of accreditation, and then monitor the site through the BEO, NTD, Trainee Assessment of Training Sites report and general feedback throughout that period.

Radiation Oncology

New sites accepted into a network are required to complete a Radiation Oncology Accreditation Self-Assessment Form. RANZCR provides assistance and advice to new sites on completing the forms and preparing the supporting documents.

The relevant CAO, along with RANZCR staff, reviews the applications and may request further information as required. Following review, RANZCR will liaise with the site to arrange an onsite assessment visit.

The onsite assessment visit is completed by the CAO or a delegated representative, another radiation oncology clinician and a member of RANZCR staff. During the site visit, questions are asked of the DOT, DOD, consultants, and management executive staff relating to the accreditation criteria and curriculum.

Following the site visit, the CAO will provide a confidential preliminary report of the visit to the NTD, DOD and DOT. The report will outline how the site was evaluated against the accreditation standards and identify any specific condition or area for improvement. The site is provided with a preliminary report and an opportunity to advise RANZCR of any inconsistencies or factual errors.



Appendices

The CAO presents the preliminary report and recommendation to the ROETC. The ROETC reviews the report, considers the CAO's recommendation, and either approves or amends the recommendation. The decision is communicated to the applying site and the NTD.

The ROETC provides the site with an assessment rating based on an A to D scale and may grant new sites accreditation provisionally within a network and restrict sites to limited periods of training at specific times within the training cycle. For example, a site may be granted accreditation to have trainees for six months at a time, in their fifth year of training.

Accreditation Outcomes

Following a site visit for Clinical Radiology, the Accreditation Panel will make a recommendation to CRTAWG, who then makes a recommendation to the CRETC. The types of accreditation which are available are:

- **Full Accreditation:** A site which is able to provide the full five-year training program, either internally or via a combination of internal & external rotations
- **Specialty Accreditation:** A site which provides training in a particular sub-specialty(ies) and receives trainees on rotation from multiple sites, e.g. Paediatric hospitals. Specialty sites are subject to the full accreditation standards, with the exception of criteria pertaining to coverage of the five-year curriculum.
- **Linked Accreditation:** A site where specific training is undertaken for certain periods. This will always be reviewed in association with a Full site. The 'Full Accreditation' site is responsible for monitoring the rotation and training experience.

For Radiation Oncology, there is no categorisation of accreditation as above.

Clinical radiology accredited sites will be granted an overall level from A-D, based on the assessment of the Accreditation Panel however it should be noted that not all criteria in the Standards are weighted equally.

The Levels for established sites are:

- **Level A:** Completely satisfactory in all areas, no significant issues, suggestions for improvement only.
- **Level B:** Satisfactory in most areas, some issues noted which require correction but are not significant enough to prevent extension of accreditation.

Accreditation outcome for Level A and B is Extend to three/five year date as per normal accreditation cycle:

- **Level C:** Significant issues noted which must be corrected before accreditation can continue long-term.
- **Level D:** Multiple significant issues seriously impacting quality of training. Immediate action required, future accreditation in doubt.

Accreditation outcome for Level C and D is Conditions applied to accreditation, extend short-term only, until issues satisfactorily addressed.

For new sites the Levels are:

- **Level A:** Good potential training experience, no concerns with proposed training program. Outcome is Accredited.
- **Level B:** Good potential training experience, some concerns with proposed training program which require monitoring. Outcome is Accredited – Provisional.
- **Level C:** Significant concerns noted with proposed training program which must be addressed before a training program can commence. Outcome is Not Accredited.

- **Level D:** Multiple significant concerns with proposed training program, site not considered appropriate for training. Outcome is Not Accredited.

Outcomes for the Radiation Oncology Accreditation Assessment also includes results for the network arrangements as listed next.

Results for the Network Arrangements:

- **Level A:** means Completely satisfactory in all network sites, no significant issues, suggestions for improvement only.
- **Level B:** Satisfactory in all network sites, some issues noted in one or more network sites which require correction but the issues are not significant enough to prevent extension of accreditation

Accreditation outcome for Level A and B is Extend to three/five year date as per normal accreditation cycle:

- **Level C:** Significant issues noted in one or more network sites which must be corrected before accreditation can continue long-term
- **Level D:** Multiple significant issues in one or more network sites seriously impacting quality of training. Immediate action required, future accreditation in doubt

Accreditation outcome for Level C and D is Conditions applied to accreditation, extend short-term only, until issues satisfactorily addressed.

Accreditation Monitoring, Evaluation and Review

All clinical radiology accredited sites must complete the biannual census to provide RANZCR with current details of consultant staff, trainees and workload. There is an annual survey for DOT and an annual survey of trainees.

For radiation oncology the census for each site is also biannual. The Trainee Assessment of Training Sites is a rating assessment of the training site in terms of training experience. Trainees complete these every six months as part of training. This assessment provides valuable information for the accreditation of training sites as it is a predictor of any training issues and enables RANZCR to guide any future training and accreditation requirements.

Faculty Councils (Clinical Radiology and Radiation Oncology) evaluate processes, appointments and policies in regard to accreditation, which address issues that arise.

The Education Training Committees for both Faculties also assess and make determinations on matters regarding accreditation, including but not limited to new site applications, site visits, progress reports and accredited sites at risk.

Moving forward to assist the Clinical Radiology Education and Training Committees, the Clinical Radiology Training Accreditation Working Group has been established.

RANZCR practices continuous improvement in accreditation with staff constantly reviewing and identifying areas of improvement required for accreditation practices.

Accreditation Framework Review

A review of the accreditation standards for both Clinical Radiology and Radiation Oncology was planned for 2020. This review will seek to align the training site accreditation standards with the program reforms being finalised through the Training and Assessment Reform Project. For Clinical Radiology this will include



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finalisation of the accreditation standards for training networks (which already exist for Radiation Oncology), and the inclusion of specific standards for bullying, harassment, discrimination and cultural awareness.

As part of the planned work in this area, a paper-based review of RANZCR's accreditation standards mapped against AHMAC agreed domains, the AMC accreditation standards and standards of other colleges will be undertaken to identify gaps and areas for improvement

In 2018, RANZCR established the Indigenous Taskforce to consider evidence-based strategies in addressing Indigenous health outcomes within RANZCR's domains of workforce, training and health policy. The aim was to develop a direction for efforts to prioritise activities and align them with AMC standards. The taskforce reviewed activities, including successful initiatives by other medical colleges, in formulating its recommendations. In this, RANZCR will consider community perspectives. Key findings will be incorporated into accreditation framework reviews, to ensure areas are addressed.

Accreditation Data Management

All Committee decisions regarding accreditation are recorded in Education and Training Committee minutes, which are stored on a centralised RANZCR database. Outcome documentation and all information regarding accredited training sites are kept in individual site folders within the database.

The Accreditation team utilises internal spreadsheets (including risk registers for both Faculties) to track and monitor the accreditation statuses of sites, as well as outcomes.

Appendix K1: RANZCR Radiation Oncology Accreditation Standards for Network Arrangements

The below table outlines the Radiation Oncology Accreditation Standards for Network Arrangements. Full details can be found at the RANZCR website.¹⁸⁸

Table 13 RANZCR Radiation Oncology Accreditation Standards for Network Arrangements

Standard 1.1 Governance	
A clear governance structure in relation to training delivery in each network is a key element of the network system. The following standards outline the key minimum criteria and requirements to meet satisfactory training network governance arrangements.	
1.1.1 The network is structured according to the Network Training Policy (NTP).	<ol style="list-style-type: none"> 1. The network is comprised of a minimum of two training sites. 2. At least two of the training sites are administered separately. 3. The training sites are separated geographically. 4. The trainees are supervised by different radiation oncologists within the network sites. 5. The training sites complete a Census, when requested by the RANZCR.
1.1.2 Within the network, there is a structured NGC responsible for training delivery which functions according to the requirements specified in the NTP.	<ol style="list-style-type: none"> 1. The NGC is structured according to the NTP. 2. The NGC holds meetings according to the NTP. 3. The NGC has defined objectives and appropriate scope consistent with the requirements of the NTP. 4. NGC adheres to the RANZCR policies and guidelines; such as but not limited to: <ul style="list-style-type: none"> • Radiation Oncologist (RO) Performance and Progression Policy 2017 • RO Remediation Policy 2017 • RO Withdrawal from Training Policy 2017 • Grievance Policy (in relation to discrimination, harassment and bullying) • Clinical Supervision and 'Protected' Time for Trainees and Directors of Training – Practical Guideline RANZCR Code of Ethics. 5. NGC has clearly defined policies and procedures to manage local issues.

¹⁸⁸ RANZCR Radiation Oncology Accreditation Standards and Criteria for Training Networks and Sites, <https://www.ranzcr.com/search/radiation-oncology-accreditation-standards-and-criteria-for-training-networks-and-sites>



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Standard 1.1 Governance

1.1.3 The network has a TND endorsed by the ROETD who is adequately supported to fulfil the role.	<ol style="list-style-type: none"> 1. The NGC is structured according to the NTP. 2. The NGC holds meetings according to the NTP. 3. The NGC has defined objectives and appropriate scope consistent with the requirements of the NTP. 4. NGC adheres to the RANZCR policies and guidelines, such as but not limited to: <ul style="list-style-type: none"> • RO Performance and Progression Policy 2017 • RO Remediation Policy 2017 • RO Withdrawal from Training Policy 2017 • Grievance Policy (in relation to discrimination, harassment and bullying) • Clinical Supervision and 'Protected' Time for Trainees and Directors of Training – Practical Guideline • RANZCR Code of Ethics. 5. NGC has clearly defined policies and procedures to manage local issues.
1.1.4 The TND fulfils the RANZCR role description as per the NTP.	<ol style="list-style-type: none"> 1. The TND complies with the RANZCR reporting requirements. 2. The TND facilitates the operation of the Network. 3. The TND attends relevant RANZCR activities.
1.1.5 The network has identified individual/s in network roles as specified in the NTP.	<ol style="list-style-type: none"> 1. Each training site within the network has a minimum of one DOT. 2. The network has an ESO.

Standard 1.2 Network Training Environment

Each network must build and continuously evolve its training environment across its constituent training sites. To be accredited for training, all networks must, as a minimum, meet the following training and facility standards.

1.2.1 The network has a standardised, implemented and shared educational program.	<ol style="list-style-type: none"> 1. The shared educational program is provided across all sites within the network and is aligned to the curriculum. 2. The shared educational program is easily accessible by all trainees in the network. 3. The network has identified the educational strengths and weaknesses of its training sites and structured the shared educational program accordingly.
1.2.2 The network shared educational program ensures trainees are exposed to a variety of learning environments.	<ol style="list-style-type: none"> 1. The network ensures trainees have access to all educational experiences, RANZCR-supported educational activities and faculty teaching courses. 2. The network provides trainees access to multi-disciplinary team meetings and clinics in keeping with curriculum requirements. 3. The network provides trainees access to direct management of inpatients admitted under Radiation Oncology teams for a minimum of 20% of their total five year training time.

Standard 1.2 Network Training Environment

1.2.3 The network develops processes to facilitate the provision of training experiences necessary to fulfil the curriculum requirements	<ol style="list-style-type: none"> 1. The network ensures that each training site is allocated trainees (according to their eligibility) across the breadth of training. 2. The network ensures trainees are exposed to the training experiences necessary to fulfil the requirements of the curriculum within the required timeframe. 3. The network tracks the experiences of individual trainees. 4. Trainees are provided the opportunity to complete the practical requirements of the curriculum. 5. Trainees are provided the opportunity to complete a research project.
1.2.4 The network continues to evaluate the training experiences delivered across its constituent sites and responds to feedback.	<ol style="list-style-type: none"> 1. The network reviews feedback from trainees and clinical supervisors.
1.2.5 The network provides all trainees access to, and practical experience with, the following techniques and services, in keeping with training program curriculum requirements.	<ol style="list-style-type: none"> 1. The network provides all trainees access to, and practical experience with, the following techniques and services (within the specified requirements).
1.2.6 The network fully supports the complete five year training program.	<ol style="list-style-type: none"> 1. The network offers trainee/s, the five years (FTE) of training required by the curriculum, assuming satisfactory trainee progress.
1.2.7 The network provides a safe working environment free from any bullying, harassment, or discrimination.	<ol style="list-style-type: none"> 1. The network offers trainee(s), regular opportunities to discuss with DOTs or the TND any issues of bullying, harassment, or discrimination confidentially. 2. The TND is aware of and complies with the RANZCR Grievance Policy and facilitates the use of the policy if required, at the request of a trainee.
1.2.8 The network ensures appropriate additional technology is available to support learning.	<ol style="list-style-type: none"> 1. The NGC requests training site updates on the availability of appropriate technology to deliver the shared educational program.



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Network Workforce Arrangements

The following standards outline the important principles surrounding recruitment, retention, supervision and support of the trainee workforce within training sites.

1.2.9 The network ensures that its constituent sites are committed to sustainable training practices.	<ol style="list-style-type: none"> 1. The network and its constituent sites commit to security in training. 2. The network and its constituent sites demonstrate ethical and consultative practices in regards to changes to trainees' employment. 3. The network and its constituent sites demonstrate a comprehensive commitment to the value of education and training. 4. The network and its constituent sites ensure economic sustainability for training commitments. 5. The network has a sufficient number of trainees to provide adequate peer support and optimise the educational experience NB: It is noted that HR requirements may differ significantly across countries.
1.2.10 The network ensures adequate supervision of trainees	<ol style="list-style-type: none"> 1. The network and its constituent training sites comply with the RANZCR Radiation Oncology Clinical Supervision and 'Protected' Time for Trainees and Directors of Training – Practical Guideline.
1.2.11 The network follows processes for selection and appointment of trainees according to the requirements of the NTP.	<ol style="list-style-type: none"> 1. When recruiting trainees, the network advises applicants that they will be expected to rotate between training sites. Networks that have rural and smaller sites will have more senior (Year 3, 4, 5) trainees rotated to their sites as well as junior (Year 1, 2) trainees. 2. The NGC has a role in recruitment and selection. 3. There is a network-wide process of recruitment, selection and appointment. 4. A clear and transparent procedure for selection and appointment of trainees is in place.
1.2.12 The network manages trainee terms and rotations according to the requirements of the NTP.	<ol style="list-style-type: none"> 1. Trainees cannot train at any one site for more than four years. They must rotate to a separate training site for a minimum of 12 months (in total) prior to sitting their Phase 2 examination. If there are rural and smaller sites within the Network, the trainee is expected to rotate to those sites if selected. This may occur in Year 3, 4 or 5 of their training and not just at Year 1 or 2. 2. Trainee rotations within the network are prospectively planned. 3. Trainee rotations between network sites are reciprocal. It is expected that a fair and equitable distribution of trainee rotations is followed, especially with respect to rural and smaller sites where senior trainees (Year 3, 4, 5) are expected to rotate. 4. Rotations between network sites are of six months duration, as a minimum. 5. Trainee concerns regarding rotations are appropriately addressed.

Appendix K2: RANZCR Radiation Oncology Accreditation Standards for Network Training Sites

The below table outlines the Radiation Oncology Accreditation Standards for Network Training Sites. Full details can be found at the College website.¹⁸⁹

Table 14 RANZCR Radiation Oncology Accreditation Standards for Network Training Sites

Standard 2.1 Governance		
A clear governance structure in relation to training delivery in each training site is a key element of the network system. The following standards outline the key minimum criteria and requirements to meet satisfactory training network governance arrangements.		
2.1.1	The training site identifies with an endorsed network.	<ol style="list-style-type: none"> 1. Site meets definition as per Standard 1.1.1 (Criteria 1–4). 2. Site signs a Memorandum of Understanding, or equivalent, with the network.
2.1.2	The training site adheres to the RANZCR reporting requirements as relevant to curriculum implementation and network operations.	<ol style="list-style-type: none"> 1. DOT complies with the RANZCR reporting requirements. 2. DOT encourages trainees to comply with the RANZCR reporting requirements. 3. DOD ensures that the RANZCR is advised of changes to DOT Site notifies RANZCR of any change of circumstances within their department which may potentially lead to its failing to meet the minimum criteria for its accreditation status. 4. Site applies to CAO for approval of any additional training positions or an increase in maximum trainee number.
Standard 2.2 Network Training Environment		
Each training site within a network must build and continuously evolve a training environment. To be accredited for training, all training sites must, as a minimum, meet the following training requirements.		
2.2.1	The training site delivers a commitment to effective communication, cultural awareness and ethical conduct.	<ol style="list-style-type: none"> 1. Effective communications. 2. Cultural awareness. 3. Ethical criteria.
2.2.2	The training site participates in, and contributes to, a formal network education program aligned to the curriculum.	<ol style="list-style-type: none"> 1. Site contributes to network activities. 2. Site provides access for trainees to attend network educational activities.

¹⁸⁹ <https://www.ranzcr.com/search/radiation-oncology-accreditation-standards-and-criteria-for-training-networks-and-sites>



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Standard 2.2 Network Training Environment

2.2.3 The training site provides a formal internal education program	<ol style="list-style-type: none"> 1. Site provides an internal educational program aligned to the curriculum. 2. Site ensures trainees have access to educational activities which may include but not limited to those listed in the evidence section. 3. Trainees at the training site have access to appropriate RANZCR-supported educational activities and Faculty teaching courses.
2.2.4 The training site provides training experiences necessary to fulfil the curriculum requirements.	<ol style="list-style-type: none"> 1. Trainees are provided the opportunity to complete the practical requirements of the curriculum.
2.2.5 The training site complies with the RANZCR Guideline Clinical Supervision and 'Protected' Time for Trainees and Directors of Training – A Practical Guideline.	<ol style="list-style-type: none"> 1. The training site provides the mandatory hours required for trainees to spend in supervision, training and teaching onsite. 2. Each site within the Network allocates dedicated time for clinical supervisors for formal and informal teaching and training of radiation oncology trainees.
2.2.6 The training site provides time, resources and support to ensure trainees are able to meet all curriculum requirements.	<ol style="list-style-type: none"> 1. Trainees attend a tutorial program that covers the content of the curriculum. 2. The clinical service required of trainees matches the service necessary to meet curriculum outcomes. 3. Prior to the Phase 1 and 2 examination, trainees complete the required practice experiences and assessments. 4. DOT completes the range of trainee assessments as determined by curriculum requirements. 5. Trainees attend and actively participate in both new patient and follow-up clinics. 6. Trainees attend and actively participate in Multidisciplinary clinics. 7. Trainees have dedicated time for supervised planning activities including contouring and plan review. 8. Trainees have access to direct management of inpatients admitted under Radiation Oncology teams.
2.2.7 The training site provides a safe working environment free from any bullying, harassment, or discrimination.	<ol style="list-style-type: none"> 1. The training site offers trainee(s), regular opportunities to discuss with DOT or clinical supervisors any issues of bullying, harassment, or discrimination confidentially. 2. The DOT understands the RANZCR Grievance Policy and protocol to follow should an incident occur. 3. The training site liaises with site HR to access professional services, if required by the trainee.

Standard 2.3 Physical Environment

To be accredited for training, the training site must ensure the following physical environment requirements are met.

2.3.1 The training site provides adequate resources for the training of network trainees.	<ol style="list-style-type: none"> 1. The training site has the minimum standard requirements for training. 2. *Special consideration will be given to single machine departments, on application to the CAO. Factors taken into account will include: <ul style="list-style-type: none"> • Relationships with other centres. • Staff engagement in education. • Plans for future growth. • Opportunity for specific training experiences. 3. Departments without a physical linear accelerator are by definition NOT considered to be accredited sites. Special considerations will be given to situations in which trainees may be required to attend outreach outpatient clinics. Factors taken into account will include: <ul style="list-style-type: none"> • Supervision (trainees should never attend these clinics unsupervised). • Amount of time required to travel to outreach locations. • Amount of time per week spent at outreach locations. • Impacts on protected teaching time. • Appropriate accreditation status by another aligned reputable training accreditation program as evaluated by the CAO. 4. The training site has a resource library.
2.3.2 The training site is linked to a university medical school.	<ol style="list-style-type: none"> 1. The training site is: <ul style="list-style-type: none"> • In a hospital with formal links to a university-accredited teaching hospital OR • Within a network that has university affiliation.
2.3.3 The training site meets the service provision and radiation treatment facilities standards.	<ol style="list-style-type: none"> 1. The training site has access to an adequate number of hospital beds designated for its use and services by rotating resident medical officers / interns. 2. The training site consults a minimum of 750 new patients with cancer each year and provides a minimum of 650 courses of megavoltage radiation therapy per annum (520 new courses and 130 retreatments). *Special consideration will be given to small departments, on application to the CAO. Factors taken into account will include: <ul style="list-style-type: none"> • Relationships with other centres. • Staff engagement in education. • Plans for future growth. • Opportunity for specific training experiences.
2.3.4 The training site provides adequate administrative office support for trainees.	<ol style="list-style-type: none"> 1. Trainees have access to a physical environment conducive to supporting training needs. 2. Oncology medical records are available for all patient management episodes. 3. Site has adequate staff to provide administrative support for trainees' clinical duties.



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Standard 2.4 Workforce Arrangements

The following standards outline the important principles surrounding recruitment, retention, supervision and support of the trainee workforce within training sites.

2.4.1 The training site follows processes for selection and appointment of trainees according to the requirements of the NTP.	<ol style="list-style-type: none"> 1. A clear and transparent procedure for selection and appointment of trainees is in place. 2. The training site participates in the network-wide process of recruitment, selection and appointment with rural and smaller sites expected to have more senior (Year 3, 4, 5) trainees allocated to their sites as well as junior (Year 1, 2) trainees. 3. The training site is represented on the selection panel for network appointments. 4. The NGC has a role in recruitment and selection for all training positions.
2.4.2 The regulated ratio of supervisor to trainee at the training site must be adhered to at all times.	<ol style="list-style-type: none"> 1. The ratio of trainees to FTE consultant radiation oncologists is never greater than 1:1.
2.4.3 Each training site within the network has a designated DOT.	<ol style="list-style-type: none"> 1. The DOT is a FRANZCR. 2. The DOT is nominated by the site. 3. Site fully supports the DOT in their administrative and educational responsibilities. 4. DOT fulfils the requirements as specified in the NTP. 5. DOT role is reviewed annually.
2.4.4 Staffing within each training site must be adequate to support the training requirements of the curriculum.	<ol style="list-style-type: none"> 1. There is a minimum of two FTE consultant radiation oncologists with an active clinical workload. * Special consideration will be given to departments who have less than 2 FTE, on application to the CAO. Factors taken into account will include: <ul style="list-style-type: none"> • Relationships with other centres. • Staff engagement in education. • Plans for future growth. • Opportunity for specific training experiences. 2. Non-medical staff, including medical physicists, radiation therapists, nurses and allied health workers, are available to support the training experience. 3. Trainees have the opportunity to communicate with other medical specialists as relevant to individual patient care. 4. ESO.

Appendix K3: RANZCR Clinical Radiology Accreditation Standards for Network Training Sites

The below table outlines the Radiation Oncology Accreditation Standards for Network Training Sites. Full details can be found at the RANZCR website.¹⁹⁰

Table 15 RANZCR Clinical Radiology Accreditation Standards for Network Training Sites

Goal 1	The Training Site promotes the welfare and interests of trainees. While the College recognises the differing requirements of workplace policies across jurisdictions, there is still a responsibility to ensure that training departments support trainee welfare. This may require new policies to be drafted however it may be more appropriate simply to ensure adherence to existing policies applicable to trainee welfare.	
1.1 Trainee Management The training site provides effective organisational structures for the management of trainees.	1.1.1	The training site provides sufficient resources to manage trainees.
	1.1.2	The training site manages trainee grievances effectively.
	1.1.3	The training site has an effective process for rostering trainee staff.
	1.1.4	The training site is responsible for actively participating in the management of the network, if applicable.
1.2 Trainees not performing and/or progressing as expected The training site identifies and supports Trainees not performing and/or progressing as expected.	1.2.1	The training site is effective in the early identification of trainees not performing and/or progressing as expected.
	1.2.2	The training site provides access to structured support for trainees not performing and/or progressing as expected coordinated at rotation, training site and network level as appropriate.
1.3 Safe Practice The training site provides an environment that supports the safety of trainees.	1.3.1	The training site provides sufficient resources to manage trainees.
1.4 Promoting Trainee Interests The training site promotes trainees' interests through representation and advocacy, in relation to radiological training.	1.4.1	The training site engages trainees and their advocates in decision making.
	1.4.2	The DOT supports and advocates effectively for trainees.
1.5 Supporting Trainees The training site supports trainees in taking responsibility for their self-care and provides access to personal support mechanisms to improve the well-being of trainees.	1.5.1	The training site supports trainees in taking responsibility for their personal health and well-being.

190 RANZCR Accreditation Standards for Education, Training and Supervision of Clinical Radiology Trainees, <https://www.ranzcr.com/search/accreditation-standards-for-clinical-radiology-training>



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1.6 Physical Environment The training site provides a physical environment, resources and amenities that enable trainees to perform their work and to engage in learning and teaching activities.	1.6.1	The training site provides an accessible, safe, comfortable work area with a range of amenities.
	1.6.2	The training site provides the appropriate physical environment to support trainees in meeting the requirements of the Radiodiagnosis Training Program Curriculum.
	1.6.3	The training site provides the appropriate physical resources to support trainees in meeting the requirements of the Radiodiagnosis Training Program Curriculum.

Goal 2 The Training Site ensures Clinical Radiology trainees have the appropriate knowledge, skills and supervision to provide quality patient care.

2.1 Training Site Orientation The training site provides an effective orientation for Clinical Radiology trainees.	2.1.1	The training site provides an orientation to all Clinical Radiology trainees. Orientation will be required: <ul style="list-style-type: none"> • At the commencement of the training year. • When a trainee commences at a new training site.
	2.1.2	At orientation the training site ensures that trainees have the clinical information and skills required to commence work.
2.2 Supervision, Training and Teaching The training site complies with the RANZCR Policy on Supervision, Training and Teaching of Clinical Radiology Trainees.	2.2.1	The training site provides the mandatory hours required for trainees to spend in supervision, training and teaching onsite.
	2.2.2	The training site enables Clinical Supervisors to provide the mandatory hours for active supervision to trainees.
	2.2.3	The training site provides the mandatory number of protected hours per week to trainees for study and or teaching.
	2.2.4	The training site provides the mandatory number of hours for protected time to Directors of Training to perform their duties.
	2.2.5	Accreditation of training time for trainees working after hours or on call rosters.
	2.2.6	Maximum number of Examinations per Consultant.
	2.2.7	Consultant to Trainee Ratio.

Goal 3 The Training Site provides a wide range of educational and training opportunities for trainees that are aligned with the requirements of the Radiodiagnosis Training Program Curriculum. (Sites are expected to see trainees through the full five year program, subject to trainees satisfying the required training milestones)

3.1 Radiodiagnosis Training Program Curriculum	3.1.1	Training is Provided on Key Conditions in Year 1 of training.
	3.1.2	Training is Provided on Body Systems Syllabuses.
	3.1.3	Training Site meets Experiential Training Requirements.
	3.1.4	Training Site Provides Patient Safety Training.
	3.1.5	Provision of training on Report Writing.
	3.1.6	Provision of training on Non-Medical Expert Roles.
3.2 Formal Education Program The training site participates in a formal network education program for trainees or provides its own education program.	3.2.1	The training site provides a formal and structured education program.

<p>3.3 Consultant Involvement The training site provides adequate human resources for the provision of supervision, training and teaching that meets the requirements of the Radiodiagnosis Training Program Curriculum.</p>	<p>3.3.1 The DOT ensures that all clinical supervisors are involved in supervision, training and teaching and are aware of their responsibilities.</p>
<p>3.4 Assessment and Feedback.</p>	<p>3.4.1 The Training site allows Directors of Training and Clinical Supervisors to assist Trainees with meeting the assessment and feedback requirements as dictated in the Radiodiagnosis Training Program Curriculum.</p> <p>3.4.2 The training site is aware of and implements as necessary the RANZCR Policies entitled Performance and Progression (Clinical Radiology) Policy, Remediation in Training (Clinical Radiology) Policy, Withdrawal from Training (Clinical Radiology) Policy. These policies prescribe processes for the identification, support, assessment, monitoring and management of trainees not performing and/or progressing as expected</p>



Appendix L: Royal College of Pathologists Australasia (RCPA)

The RCPA, established in 1956, is the leading organisation representing Pathologists and Senior Scientists in Australasia. Its mission is to train and support pathologists and senior scientists and to improve the use of pathology testing to achieve better healthcare.

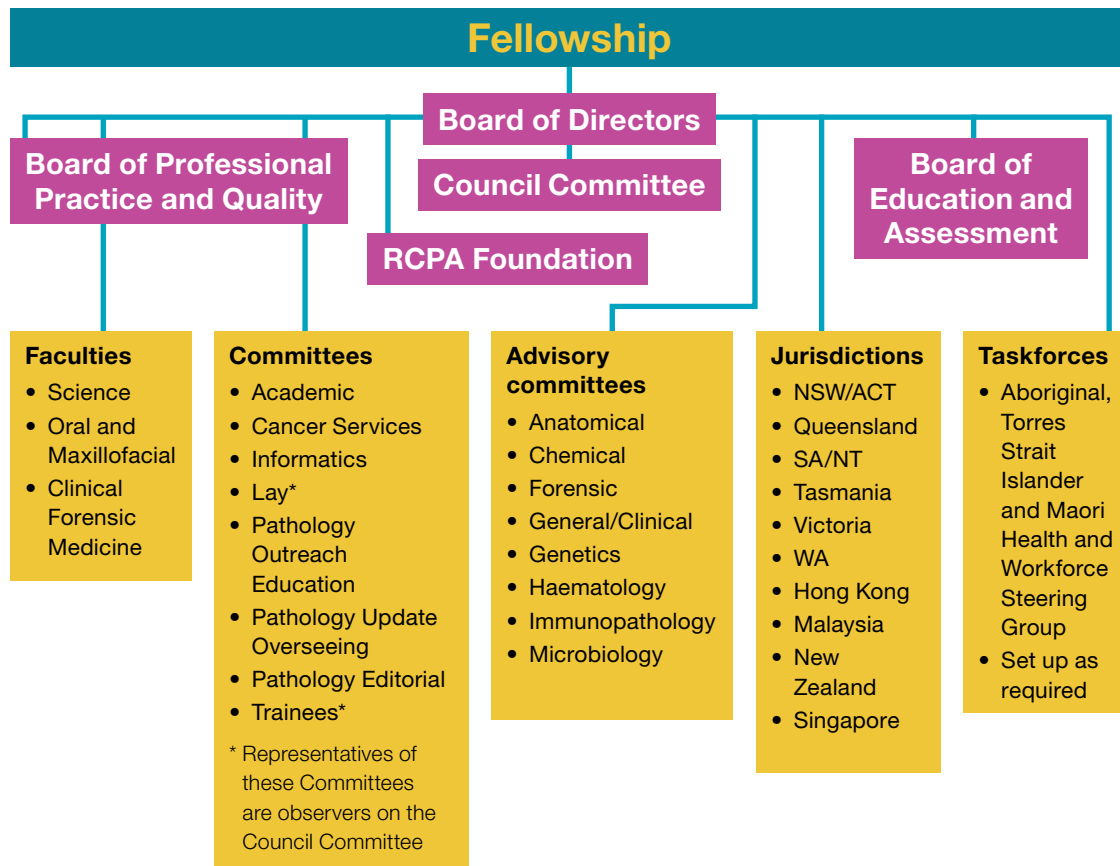
In 2016, the RCPA received AMC/MCNZ accreditation for ten years, subject to annual reports and a comprehensive assessment in 2020. The RCPA has now addressed all recommendations and met all of the conditions arising from the 2016 assessment. This has largely been achieved in advance of the required timeframes.

College Governance

The RCPA is governed by a number of Committees. The principal governing body is the Board of Directors. In addition the RCPA comprises the following committees:

- Council
- Board of Education and Assessment (BEA)
- Board of Professional Practice and Quality.

There are also State and Regional Committees and Advisory Committees representing the various disciplines of pathology. The governance structure is shown in Figure 3 below.

Figure 3 RCPA Governance Structure¹⁹¹

College Board of Directors

The Board is the governing body of the RCPA. The Directors of the Board are the President, Vice-President, Vice-President (NZ), Secretary/Treasurer, the Chair of the Board of Education and Assessment or the Chair of the Board of Professional Practice and Quality, Chairs of the Advisory Committees, nominee of the State and Regional Councillors and a Council representative.¹⁹²

The Council Committee is tasked with strategic planning for the RCPA and meets annually to consider the issues to be prioritised in the year/s ahead. Council is made up of the Board of Directors (nine members), the State and Regional Chairs (10 members), Advisory Committee Chairs (seven members), Faculty Chairs (three members), Trainee Chair (one member), Community Advisory Committee Chair (one member), RCPA Quality Assurance Programs Chair/Rep (one member).¹⁹³ There is no specific rural or regional representative position.

191 RCPA Governance Structure, <https://www.rcpa.edu.au/About/Governance/Docs/RCPA-Governance-Structure.aspx>

192 Constitution of The Royal College of Pathologists of Australasia, <https://www.rcpa.edu.au/getattachment/798a5a60-87e8-4d27-9ed4-0143a6a72b54/Constitution.aspx>

193 The Royal College of Pathologists of Australasia, Annual Report 2018–2019, <https://www.rcpa.edu.au/getattachment/9830727b-9ed6-4671-baab-fa76427a5d6d/RCPA-Annual-Report-2018-2019.aspx>



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The BEA includes all the chief examiners for each sub discipline. The chief examiners are responsible for all accreditation decisions relating to their sub discipline.

State and Regional Chairs and Committees assist with the organisation and running of examinations in their jurisdiction which is of immense value to the RCPA. All State and Regional Chairs are members of the Council Committee which meets annually to consider and direct future strategic planning for the RCPA.

College Membership

In 2018, the RCPA had 1,299 Fellows of the RCPA (FRCPA) and 676 joint Fellows of the RCPA/ RACP.¹⁹⁴ Also in 2018, the RCPA had 278 pathology trainees and 276 joint pathology/ physician trainees.¹⁹⁵ The RCPA reported the numbers of Fellows by subspecialty in 2018 for 2017 as shown in Table 15 below.

The RCPA has applied to the Australian Health Practitioner Regulation Authority (AHPRA) for recognition of Clinical Forensic Medicine as a medical specialty.

Table 16. Pathology Fellows by Subspecialty and Gender for 2017 (reported 2018):¹⁹⁶

Subspecialty	Male	Female	Total
Pathology – anatomical pathology (including cytopathology)	432	447	879
Pathology – chemical pathology	47	33	80
Pathology – forensic pathology	30	20	50
Pathology – general pathology	59	15	74
Pathology – genetic pathology	12	6	18
Pathology – haematology	306	231	537
Pathology – immunopathology	71	35	106
Pathology – microbiology	121	100	221
Pathology – oral Pathologists	8	2	10
Total	1086	889	1975

Pathology Workforce

A large number of sites are run by private industry with three major private operators with many of the workforce based in metropolitan centres, reflecting one of the challenges for rural expansion of specialty training.

194 Data obtained from the DoH's Data Portal. Medical Education and Training Data Set 2018. Table 4.53: Fellows by medical specialty and state/territory, 2018. <https://hwd.health.gov.au/resources/data/summary-met4-2019-4.53.pdf>

195 Data obtained from the DoH's Data Portal. Medical Education and Training Data 2018. Table 4.3: Vocational training positions/trainees by medical specialty, 2018. <https://hwd.health.gov.au/resources/data/summary-met3-2018-4.3.pdf>

196 Data obtained from the Department of Health's Data Portal. Medical Education and Training Data 2018. Table 4.55: Pathology Fellows: Total, females and proportion of females by subspecialty in 2017, reported 2018. <https://hwd.health.gov.au/resources/data/summary-met3-2018-4.55.pdf>

Accreditation Governance

The RCPA is responsible for accrediting workplaces for the training of pathologists and Faculty members.

The BEA grants accreditation to a training site on the recommendation of the Registrar of the BEA and the relevant Chief Examiner.

The *Accreditation of Sites for Training Programs*¹⁹⁷ policy sets out the guidelines by which the RCPA will endeavour to address both accreditation and reaccreditation of laboratories or Faculty training sites.

The RCPA endeavours to ensure, as part of the accreditation process, that laboratories that have expressed an interest in, or are, providing training are appropriately staffed and equipped, and have appropriate selection, training and supervision processes in place in accordance with RCPA requirements.

This accreditation process is separate to that carried out by the National Association of Testing Authorities (NATA)/RCPA or International Accreditation New Zealand (IANZ) or other such bodies. However Fellows as part of the NATA/RCPA or IANZ site visits will discuss pathology training programs with the laboratory and provide written feedback back to the RCPA.

The RCPA has worked to make the accreditation process work and align with the NATA process as that is most relevant to pathology laboratories.

Pathology Specialty Training Program

The RCPA accredits laboratories for pathology training, approves supervised training undertaken in an accredited laboratory and conducts examinations leading to certification as a qualified pathologist and FRCPA.

The RCPA accepts applications from registered medical practitioners with a minimum of two year's post graduate experience, who wish to become a specialist pathologist. Applicants must be employed in an accredited laboratory before seeking registration with the RCPA. Laboratories are accredited for training in Australia, New Zealand, Hong Kong, Singapore, Malaysia and Saudi Arabia. The RCPA plays no part in placing applicants in employment. Pathology training takes a minimum of five years, however the RCPA does help to facilitate this via training networks where possible.

Training can be undertaken in General or Clinical Pathology or in one of the single disciplines:

- Anatomical Pathology
- Chemical Pathology
- Genetic Pathology
- General Pathology
- Forensic Pathology
- Haematology
- Immunopathology
- Microbiology.

¹⁹⁷ RCPA Accreditation of Sites for Training Programs, June 2021, <https://www.rcpa.edu.au/Library/College-Policies/Policies/Accreditation-of-Sites-for-Training-Programs.aspx>



Appendices

The RCPA also offers a Fellowship of the Faculty of Oral and Maxillofacial Pathology open to both medical and dental practitioners, and Fellowship of the Faculty of Clinical Forensic Medicine for medical practitioners and Fellowship of the Faculty of Science for Senior Scientists. The RCPA pathology training program is linked to training programs of the RACP in:

- Chemical Pathology
- Haematology
- Immunopathology
- Microbiology
- Genetics

If a trainee chooses these disciplines they may choose to undertake joint training and attain dual Fellowships of both Colleges.

Training involves five years in accredited laboratories and sitting the following three exams:

- **Basic Pathological Sciences Examination:** The examination may be taken before commencement of training. The examination is open to any intern, medical or dental student in their final year as well as registered trainees. It is usually taken in the first year of training.
- **Discipline Specialty Part I:** This is usually taken in the third year of training.
- **Discipline Specialty Part II:** This is usually taken in the fifth or final year of training.¹⁹⁸

Pathology training is different from other medical specialty training in that the first year trainee will have had no previous experience in pathology, so the training must start from the beginning.

The RCPA has implemented changes to the training for the medical and dental trainee handbooks designed to align with AMC and MCNZ accreditation standards for the curricula of the specialty training programs. The changes are intended to provide clear definition of expectations of trainees as they progress through training, particularly with respect to the 'non-technical' domains including professionalism, communication, leadership and scholarship. They are expressed as milestones at the levels of:

- Foundation – first year of training
- Core – mid program/part 1 level
- Transition to Fellowship – end of program standard.

These changes have been incorporated into the new handbooks for 2021.¹⁹⁹

198 <https://www.rcpa.edu.au/Pathology-Careers/Becoming-A-Pathologist/General-Information>

199 <https://www.rcpa.edu.au/Trainees/Curriculum>

Supervision

The policy *Supervision of Training and Accreditation of Supervisors* specifies the requirements for supervision of trainees. Allocation of a Supervisor is normally recommended by the Head of Department and negotiated with the Trainee. The Trainee may request an alternate Supervisor without penalty. Supervision is normally provided by a FRCPA or approved by the Board of Education and Assessment on presentation of a curriculum vitae.²⁰⁰

There is some flexibility around supply of supervision in the smaller disciplines. This is not possible in rural areas as there is not normally anybody else who would be suitable to be a supervisor.

All new supervisors are required to undergo training to become accredited. Supervisors must subsequently participate in a face-to-face Supervisors' Workshop once every five years. Alternatively supervisors may successfully complete the three online supervisor modules every two years. The RCPA audits for compliance with training requirements.

There is no standard ratio of pathologists to trainees because of differences in the specimen number, specimen type and complexity of samples reported by different laboratories. Assessors are asked to take into account a number of factors that collectively determine the fitness for training of a laboratory. The assessment is therefore largely a qualitative one that relies on a variety of non-quantifiable factors based on the following principles:

- Assessors consider the total number of cases the laboratory performs and the complexity of the case mix. For example, some laboratories may do small numbers of complex cases, with cases taking an hour to review while others do large numbers of less complex cases, which may only take 10 minutes.
- Assessors then review the pathologist FTEs taking into consideration clinical case load, including all the components of that work. For example, for Anatomical Pathology, numbers of surgical cases, cytology cases, frozen sections, fine needle aspirations and autopsies (foetal versus adult) need to be looked at with adjustment for complexity levels. For the other disciplines, the clinical commitment, especially for direct patient care, must be considered to ensure that there is sufficient laboratory FTE to cover service and training. In addition to clinical caseloads, other commitments such as preparation and attendance at clinical case conferences, teaching, research, administrative work and quality assurance responsibilities are reviewed.
- Assessors review the number of trainees in the department and look at work versus training commitments. A rough estimate of the amount of one-on-one training required to pass the Part 1 exam is approximately 1,500 hours for Anatomical Pathology and 750 hours for the other disciplines. The Assessors have discussions with trainees as to whether they consider they are receiving adequate training. This is critical.²⁰¹

200 RCPA Supervision of Training and Accreditation of Supervisors, November 2019, <https://www.rcpa.edu.au/getattachment/2a778b16-a89f-4aa9-b9ca-c0639b43eee8/Supervision-of-Training-and-Accreditation-of-Super.aspx>

201 RCPA Assessment of Training Programs for Accreditation of RCPA Training: Process for Assessment of Adequate Staffing Levels for Training for Fellowship of the RCPA, April 2021, <https://www.rcpa.edu.au/getattachment/8b12c439-699b-48fc-85aa-9c123f9bfd99/Assessment-of-Training-Programs-for-Accreditation.aspx>



Appendices

Rotations

Rotations are built into the training. Rotations are determined by:

- Curricula/training programs
- Training progress
- Competency
- By networks
- By jurisdictional committees.

Ordinarily, at least two years of the training program must be spent in public laboratories or other public facilities.²⁰²

Accreditation Framework

The RCPA is responsible for accrediting sites for the training of pathologists and faculty members. Accreditation ensures that sites which provide training are appropriately staffed and equipped. Site visits may be conducted during the five year accreditation period and some visits may be carried out in collaboration with representatives of the RACP where joint training programs are in place. The accreditation of training sites for Clinical Forensic Medicine is based on the capacity of the site to offer training that will enable trainees to achieve entrustment in relation to Entrustable Professional Activities as set out in the Trainee Handbook.

Accreditation Standards

The overarching standards are documented in the RCPA policy *Accreditation of Sites for Training Program*.²⁰³ They apply to all sub-disciplines, there is an appendix for additional criteria for Clinical Forensic Medicine.²⁰⁴

The criteria and requirements for accreditation of training sites is at [Appendix L1](#).

Accredited Training Sites

The maximum time any laboratory can be accredited is four years. Any training site included in a network or rotational arrangement must be accredited.

Training sites may be accredited for any or all of the major disciplines in pathology: Anatomical Pathology, Chemical Pathology, Genetic Pathology, Haematology, Immunopathology, Microbiology, and for the separate disciplines within General Pathology in addition to Forensic Pathology. This accreditation will likely also cover the laboratory component of joint training programs with the RACP.

Oral and Maxillofacial and Clinical Forensic Medicine Training Sites are accredited separately.

202 RCPA Training Limitation, June 2021, <https://www.rcpa.edu.au/getattachment/015fe62b-2d13-47c8-b0e4-27f61082ee54/Training-Limitation.aspx>

203 RCPA Accreditation of Sites for Training Programs, June 2021, <https://www.rcpa.edu.au/getattachment/8c91f1ff-321a-46a4-adb3-3cd323ad8ee6/Accreditation-of-Sites-for-Training-Programs.aspx>

204 RCPA Preliminary DOH Online Survey Response, 18 October 2019

Accreditation Process

There is a two stage assessment process for RCPA accreditation. The RCPA undertakes a paper-based assessment and if there are any issues identified, the Chief Examiners go and do a formal site assessment.

The RCPA strongly encourages training sites to participate in regional or state based rotations for trainees.²⁰⁵

Accreditation Visit

The RCPA will endeavour to visit each accredited training site once in every five year accreditation period (provided there is a trainee in a position) or as and when the need arises.

Routine visits are carried out by Fellows in conjunction with NATA/RCPA or RCPA/IANZ Laboratory Accreditation visits as outlined below. If issues are raised during these routine visits, or by other means, a full site visit may be conducted.

Visits may be carried out in collaboration with representatives of the RACP where joint training programs are in place.

Any site visit team may be determined by the Chief Examiner. The team will ordinarily consist of the appropriate Chief Examiner(s) (or nominee), State Councillor (or nominee), one other Fellow/ Faculty Fellow and, optionally, a recently-qualified Fellow/ Faculty Fellow. The RCPA will endeavour to include at least one member of the team from a different state/region.

During the visit the site visit team meet with supervisors and trainees as part of the assessment.

Accreditation Assessments

Heads of departments, who are often supervisors of training, are responsible for initiating applications for accreditation and for maintaining RCPA standards. Other supervisors at the training site have input during site visits, or they may raise concerns with the RCPA at any time via confidential channels.

The accreditation process for either new sites or reaccreditation would normally take three months.²⁰⁶

Most of the consideration of accreditation by the BEA is done out of session. Criteria for Membership of accreditation panels are:

- Fellow of RCPA
- Experience as a supervisor of specialty training
- Conflict of interest
- Accreditation experience
- Approval from the Chief Examiner in the medical sub-specialty.

The RCPA does not currently conduct accreditation surveyor training.

205 RCPA Accreditation of Sites for Training Programs, June 2021,
<https://www.rcpa.edu.au/Library/College-Policies/Policies/Accreditation-of-Sites-for-Training-Programs.aspx>

206 RCPA Preliminary DOH Online Survey Response – 18 October 2019



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Accreditation Outcomes

A training site will be notified of the outcome of the BEA accreditation consideration in an official letter. The communication to the training site will identify:

- **Scope of Accreditation for Training:** A training site may obtain accreditation in single discipline training or general training.
- **Duration of Accreditation for Training for an individual trainee:** Depending on the range of services, the caseloads and level of supervision, a training site can only be accredited for training for any individual candidate for a maximum of four years.
- **Duration of Accreditation for Training for the training site:** Once accredited, each training site will undergo reaccreditation every five years. A site visit will ideally occur at least once in those five years, provided a Trainee is in a position.

Accreditation Monitoring, Evaluation and Review

Biennial surveys of trainees, supervisors and other fellows involved in training also address issues relating to site accreditation.

There is an annual paper based audit in relation to accreditation, looking at what, if any changes have occurred at each accredited training site.

RCPA staff members generally visit most sites annually, checking in with the trainees and supervisors informally. A formal site visit will be organised if any major concerns are raised. Issues arising from NATA visits can also lead to investigation by RCPA.

The accreditation framework is reviewed on a need basis or as required. Factors that drive change are:

- Specialty training program changes
- Curriculum changes
- Supervision arrangements
- Regulatory changes (AMC, etc.)
- Government programs and
- Health services administration and management.

Accreditation Data Management

The RCPA records and monitors accreditation recommendations and outcomes in the following electronically and manually using:

- Electronically – Microsoft database (excel, access)
- Electronically – purpose built database
- An RCPA CRM.

Issues identified during the site visits, or forms for annual monitoring, or raised through complaints are documented and referred to the CEO and/or Board of Education and Assessment as required.

Appendix L1: RCPA Accreditation Standards and Criteria

Criteria and requirements for accreditation of training sites for pathology training. Full details can be found on the RCPA website.²⁰⁷

RCPA Accreditation of Sites for Training Program

STANDARD 1

Governance and management

Trainee management:

- The organisation should enable trainee participation in governance and must protect the health, safety and wellbeing of trainees.

Discrimination, Harassment and Bullying:

- The Training Site must be committed to providing a work environment that is free from discrimination, harassment, bullying, vilification and victimisation, where employees are treated with dignity, courtesy and respect.
- The Training Site must have appropriate policies and procedures to address any issues of this nature. This includes a training program for all Supervisors as to how to address issues raised of this nature, and how to deal with any complaints.
- The Training Site must work cooperatively with the College as appropriate when any issue of this nature involves Trainees, Supervisors, Fellows, Associates, Members, Affiliates, Associates of Faculties and any other individual (in respect of activities undertaken in connection with the College).

Selection of Trainees:

- Organisations running Training Sites must follow the selection process, as set out in the RCPA Guideline: Selection of Trainees.

Library/Internet Facilities:

- A reasonable number and variety of journals and up to date textbooks should be made available at the Training Site and preferably a large medical library with borrowing facilities should be conveniently located. Access to literature search and internet facilities should be available.

Equipment and Floor Space:

- These should be adequate for the volume of work undertaken.
- Trainees must have adequate work space and facilities relevant to their discipline.

Laboratory Accreditation:

- NATA/RCPA or IANZ accreditation is mandatory for laboratories in Australia and New Zealand. In laboratories outside Australia and New Zealand, accreditation to a prescribed external standard (generally International Organization for Standardization) is required. The one exception to this is for laboratories that have been approved by Chief Examiners for Trainees to undertake a research rotation as a part of their training program.

²⁰⁷ RCPA Accreditation of Sites for Training Programs, June 2021, <https://www.rcpa.edu.au/Library/College-Policies/Policies/Accreditation-of-Sites-for-Training-Programs.aspx>



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STANDARD 2

Supervision and clinical experience

Professional Staff:

- It is expected that there will be a full time specialist medical, scientific or, for training in Oral Pathology dental, graduate working in the service of the particular discipline for which accreditation is being sought. In general, this individual should be a Fellow of the College or a Fellow of the respective Faculty. Whenever this is not so, appropriate qualifications will be necessary and a full curriculum vitae of the individual should be submitted.

Supervisor:

- One of the professional staff is to be nominated as the Supervisor of the Trainee.
- Refer to the RCPA Policy: *Supervision of Training and Accreditation of Supervisors*.
- The Supervisor is required to submit a proposed training program at the commencement of each year and to complete a Supervisor's report by 20 July of each year, if the Trainee is undertaking
- An examination, or by the end of the calendar year, for inclusion with the following year's registration forms.
- The organisation running the Training Site must support Supervisors in their roles and provide appropriate resources to do so.

Clinical Experience:

- The training site and/or network provides the appropriate breadth and volume of relevant clinical experience.

STANDARD 3

Educational Opportunities

Education Program:

- The Trainee should be exposed to all aspects of the work of the Training Site, including clinical liaison and bench work, so that a thorough practical understanding of the discipline is achieved.
- Participation in conferences and seminars in the clinical environment of the organisation should be available to the Trainee.
- Trainees should also be able to attend such sessions at neighbouring organisations. Details of the education program must be given in the prospective plan submitted to the Board of Education and Assessment at the beginning of every year.

Research:

- Research opportunities are promoted, facilitated and supported by the site.

Appendix M: Acknowledgements

Specialist Medical Colleges, Associations and Societies

Australasian College of Dermatologists – Brett O'Neill, Lucy Luo

Australasian College of Emergency Medicine – Lyn Johnson, Ian Woodrow, Jenny Winger

Australian and New Zealand College of Anaesthetists – Dr Thien LeCong, Dr Mark Young, Lincoln Hoye, Stephen White

Australian Orthopaedic Association – Adrian Cosenza, Kathy Hill, Elizabeth Burrell, Dr Andrew Ellis, Ms Susi Tegen, Dr Chris Kondogiannis

Neurosurgical Society of Australia – Stacey Gull, Dr Mark Davies

Royal Australasian College of Medical Administrators – Melanie Saba, Debbie Greenberger

Royal Australasian College of Physicians – Robyn Burley, Louise Rigby, Rebecca Udemans, Shalini Purohit, Blanche Taylor, Professor Anne Cunningham

Royal Australasian College of Surgeons – Professor Julian Archer, Olivia Hartles, Veronica Vele, Elaine Tieu, Chesney O'Donnell, Andrew Rose, Lindsay Broadman-Bradley, Etienne Scheepers, Jodie Wall, Melissa Colosimo

Royal Australian and New Zealand College of Ophthalmologists – Victoria Baker-Smith, Simon Janda

Royal Australian and New Zealand College of Psychiatrists – Anna Lyubomirsky, Anita Hill

Royal Australian and New Zealand College of Radiologists – Natalia Vukolova, Pamela Spoons, Chloe Visser, Bettina Brooke

Royal Australian and New Zealand College of Obstetricians and Gynaecologists – Dr Vijay Roach, Vase Jovanovska, Dr Jared Watts, Olly Jones, Stephen White, Maheshie Jayawickrama

Royal College of Pathologists of Australasia – Dr Debra Graves

Peak Bodies

Australian Medical Association Council Doctors in Training – Dr Tessa Kennedy

Australian Medical Council – Theanne Walters

Medical Deans Australia and New Zealand – Helen Craig, Professor Ian Symonds, Professor Michelle Leech, Professor Kirsty Forrest, Professor Imogen Mitchell, Professor Richard Murray, Professor Christine Bennett, Professor John Fraser, Helen Bray



Appendices

State and Territory Health Departments

New South Wales Ministry of Health – Dr Linda Macpherson

Northern Territory Department of Health – Dr Hugh Heggie, Dr Sara Watson, Peter Boyce, Dr Mahiban Thomas

Queensland Health – Rachel Hoffman, James McNulty, Faith White

South Australia Health – Carmen Crawford, Reece Johnson, Robyn Anderson, Colleen Cryans

Tasmanian Department of Health – Dr Ruth Kearon

Victorian Department of Health – Dr Claire Langdon, Praveen Sharma, Iris Kominis, Helen Nguyen, Nigel Brand, Stephen Fox, Megha Swami

Department of Health, Western Australia – Dr Paul Myhill, Dr Michael Levitt, Gillian Munyard, Margaret Sturdy, Dr Nick Spendier, Cheryl Grigsby

Hospitals and Health Services

Alice Springs Hospital – Dr Samuel Goodwin, Dr Stephen Brady

Ballarat Health Service – Associate Professor Rosemary Aldrich, Dr Jaycen Cruickshank, David Channon, Pauline Chapman, Ben Kelly, Dr Mark Yates, Dr Heather Crook, Dr David Tekell, Dr Natasha Frawley, Mr Matthew Hadfield

Bathurst Hospital – Dr Ranjit Paul

Coffs Harbour Health Campus and Port Macquarie Hospital, Mid North Coast Local Health District – Dr Jo Burnand, Dr Theresa Beswick, Dr Shehnarz Salindera, Julie Sillince

Dubbo Base Hospital, Western NSW LHD – Dr Clayton Spencer, Jodie Spencer, Dr Geoffrey Hardacre, Renee Hodges, Dr Mark Rice

Gove Hospital – Dr Marco Briceno

Kathrine Hospital – Dr Louise Harwood

Latrobe Regional Hospital – Peter Craighead, Don McRae, Dr Philippa Hawkings

Launceston General Hospital – Dr Peter Renshaw

Mackay Base Hospital – Dr David Farlow

North West Hospital, Burnie – Dr Kathleen Atkinson, Dr Deb Hickling, Dr Shehzad Kunwar

Orange Health Service – Dr Sid Vohra, Professor Scott Clark

Port Augusta Hospital – Professor Guy Maddern

Port Pirie Hospital – Roger Kirchner, Michael Eades, Joanna Vermeeren

QLD Rural Medical – Dr Hwee Sin Chong, Dr Spencer Toombes, Dr David Pearson, Dr Paul Jauncey, Dr Vanaja Sabesan, Dr Dilip Dhupelia

Royal Darwin Hospital – Dr Charles Pain, Dr Didier Palmer, Dr Karen Stringer, Dr David Simon, Dr Keith Forrest

Royal Hobart Hospital – Dr Stephen Ayre, Dr Sean Beggs

Shoalhaven Hospital, Illawarra Shoalhaven Local Health District – Craig Hamer, Dr Chun Yee Tan

South East Regional Hospital – Dr Elizabeth Mullins, Dr Lachlan Gordon

St John of God Ballarat – Dr Vincent Russell

St John of God, Bunbury – Dr Keith Allenby, Kristy Cochrane

Tamworth Rural Referral Hospital – Yvonne Patrick

Townsville Hospital and Health Service – Dr Andrew Johnson, Dr Jon Hodge

WA Country Health Service – Dr Andrew Jamieson, Dr David Oldham, Dr Natalia Magana, Dr Sue Phillips, Dr Greg Watters

Whyalla Hospital and Health Service, Flinders Upper North LHN – Craig Packard, Dr Nes Lian-Lloyd, Dr Kean Kuan, Dr Ferdous Alam, Dr Nigel Stewart

Regional Training Hubs

Eyre Peninsula and Spencer Gulf RTH, University of Adelaide – Professor Lucie Walters, Tracy Jayne Paterson, Jenna Kerslake, Dee Risley

Gippsland Regional Training Hub, Monash University – Dr Michael Nowotny, Larissa Attard

Goulburn Valley Regional Training Hub, University of Melbourne – Professor Julian Wright, Shane Boyer, Angela McLeod

North West NSW, University of Newcastle – Professor Jenny May, Dr Lisa Dark

North West Tasmania, University of Tasmania – Assoc Prof Debbie Wilson

Northern Queensland Regional Training Hubs, James Cook University – Professor Richard Murray, Marcelle Crawford, Andrea Muller

Northern Territory – Alice Springs, Flinders University – Professor Sam Heard, Karen Montey

Northern Territory – Darwin, Flinders University – Dr Olivia O'Donoghue

Southern Queensland, Wide Bay and Central Queensland, University of Queensland – Professor Sarah Strasser, Dr Steve Flecknoe-Brown, Debbie Croyden, Dr Matthew McGrail, Dr George Tucker, Dr Tom Doolan

WA Regional Training Hubs, University of Western Australia – David Atkinson, Carol Chandler, Tracey Isidori, Denese Playford, Dr Bek Ledingham, Brian Cunningham

Western Victoria Regional Training Hub, Deakin University – Associate Professor Barry Morphet



Appendix N: Consultation Questions

Appendix N1: Online Preliminary Survey for Specialist Medical Colleges

Online Preliminary Survey Questions

1. Please outline the accreditation governance framework for the College including who has final approval of accreditation recommendations and outcomes.
2. Does the accreditation process and/or governance differ per sub-specialty?
 - Yes
 - No
 - Not applicable.
 - If Yes, please explain how.
3. Please identify how overarching College accreditation standards are applied to sub-specialties. (If the college does not have sub-specialties, go to next Q.)
4. Who in the College has ownership and responsibility for the accreditation framework and accreditation functions? Please select all that apply:
 - Jurisdictional committees
 - Specialty associations/societies
 - College National (Australia and New Zealand central office)
 - Accreditation committee
 - Education and training committee
 - College Board
 - Other.
 - Please provide additional details if required.
5. Please identify influences that impact the location and geographical distribution of specialty training for your college? Select all that apply:
 - Specialty College
 - Education and training committee
 - Specialty society / association
 - Government programs
 - College Fellows
 - Accreditation committee
 - Jurisdictional committee
 - Other. If other, please provide details.

6. What is the role of Directors of Training / Coordinators of Training / Supervisors of Training, if any, in the accreditation process?
7. What criteria are considered in determining the composition of accreditation panels?
- Member of accreditation committee
 - Fellow of college
 - Experience as a supervisor of specialty training
 - Conflict of Interest
 - Jurisdictional committee member
 - Director of Training
 - Coordinator of Training
 - Supervisor of Training
 - Fellow in sub-specialty
 - Special interest member – rural, private etc.
 - Accreditation experience
 - Community representation
 - Trainee representation, other. If other, please provide details.
8. Does the College conduct accreditation panel assessor /surveyor training?
- Yes
 - No
 - If so, what is the frequency?
 - Biannually
 - Annually
 - Biennially (every two years)
 - Other
 - Not applicable
9. Please identify the elements required for training posts, health settings or networks to consider when establishing a new specialty training post for accreditation.
- Accredited health service
 - Health service size
 - Accredited services available at health setting
 - Availability of supervisors
 - Case mix
 - Case numbers
 - Capacity to train
 - Logbook data
 - Suitable position description for training requirements
 - Organisational policies to support training (trainees and supervisors)
 - Other – please provide details.
10. What are the main drivers of change in the college accreditation framework? Please select all that apply:
- Specialty training program changes
 - Curriculum changes
 - Supervision arrangements
 - Regulatory changes (AMC, etc.)
 - Government programs
 - Other – please provide details.
11. How frequently does the college review the accreditation framework?
- Annually
 - 2 years
 - 3 years
 - 4 years
 - 5 years
 - As required
 - Haven't yet reviewed.
12. What changes in accreditation have evolved over time for your College to better meet the needs of trainees and improve support of specialty training?



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13. What changes in accreditation have evolved over time for your College to better meet the needs of supervisors of specialty training?
14. Please identify any changes in your College accreditation framework that have evolved over time to better support health settings to deliver high-quality and safe specialty training.
15. Does the College consider community need under the accreditation framework?
- Yes
- No
- If so, how?
16. Which other entities do you collaborate with (if any) in the accreditation of training posts, health settings and network?
- Rural Doctors Association Australia
- National Aboriginal Controlled Health Organisation
- Australian Indigenous Doctors Association
- Aboriginal Community Controlled Health Services
- Jurisdictions
- Regional Training Hubs
- Other Colleges
- Other
- Not Applicable
- If Other, please identify entities.
17. Are training rotations built into accreditation recommendations?
- Yes
- No
- Sometimes
- Not applicable
18. How are training rotations determined?
- Curricula/training programs
- Training progress
- Competency
- By the College
- By Networks
- Societies/associations
- Jurisdictional committees
- Other – please provide details.
19. How does the college record and monitor accreditation recommendations and outcomes?
- Electronically (Microsoft Excel, Access)
- Electronically (purpose built database)
- Electronically online platform (sole college)
- Electronically online platform (multi-college)
- Electronically and Manually
- Manually
- Other – please provide details.
20. Does the accreditation framework and data management for your college have the capacity for monitoring and reporting of accreditation issues?
- Yes
- No
- Other – If yes or other, please provide details.
21. Does the College have an evaluation mechanism built into the overarching accreditation framework or process?
- Yes
- No
- If so, please explain how this occurs, the frequency and who is involved in evaluation.
22. Does the College accept applications for accreditation at any time?
- Yes
- No
- Other – if other please provide details.

23. If there is a set application period, when do applications open and close? Please provide details.
24. Please identify the length of time required to process and accreditation application and accredit a new post, health setting or network.
- 3 months
 - 6 months
 - 9 months
 - 12 months
 - 18 months
 - Variable
 - Other – if other or variable, please provide details.
25. Please identify the length of time required to re-accredit existing posts, health settings or networks.
- 3 months
 - 6 months
 - 9 months
 - 12 months
 - 18 months
 - Variable
 - Other – if other or variable, please provide details.
26. Does the accreditation process impact the ability of the College to respond to government funding programs and initiatives?
- Yes
 - No
 - Sometimes
 - If Yes or Sometimes, please describe how.
27. Please identify what changes to posts would require re-accreditation.
- Changes to networks
 - Changes in supervisors
 - Changes in service delivery
 - Changes to training position
 - Organisational changes – workforce, policies, etc.
 - Other – please provide details
28. Are logbooks used by trainees to record progress towards meeting specialty training program requirements??
- Yes
 - No
 - If so please identify what is recorded in logbooks.
29. If trainees use logbooks, is logbook data used in accreditation?
- Yes
 - No
 - Not applicable.
 - If Yes, please provide details on how data is used.
30. Please identify any barriers to the accreditation of training posts, health settings and networks outside of metropolitan settings (in RA2-RA5 areas) for your specialty training program/s.
31. What, if any, opportunities have been identified in College accreditation to support the increased distribution of specialist training in rural and regional Australia?
32. Please provide examples of successful rural and regional training models accredited for specialist medical training for your college.



Appendix N2: Specialist Medical Colleges

Face to Face Consultation Questions – Generic

1. What do you think are the challenges within the current specialist medical college accreditation frameworks in terms of how accreditation impacts on the development of non-metropolitan specialist training pathways? What is the biggest challenge impacting your organisation?
2. What elements of the current specialist medical college accreditation frameworks are working well? What are the key components that are critical to maintaining quality training and patient safety that need to be maintained into the future?
3. How could specialist medical college accreditations frameworks be improved for better geographical distribution of specialist medical training and in specialities that communities need?
4. What are the key activities for your organisation during an accreditation process (pre-application, application, assessment and decision)? What resources are required and how long does each stage usually take?
5. Do you have examples of new rural training sites successfully accredited and/or proposals that were not supported or need further work to meet the accreditation requirements?
6. What audit and quality improvement processes of accreditation activities are in place? For example to deliver change such as: flexibility, streamlining, innovation, collaboration, simplification and improve transparency?
7. How do you think your organisation can contribute to delivering more high quality regionally based medical specialist training, within the existing accreditation system?
8. How are government programs being used by your organisation to support the creation of new rural medical specialist training sites? Which programs are you participating in apart from Commonwealth programs?
9. If your organisation is involved in accreditation activities across the medical education and training continuum (medical school, prevocational and vocational training) can you think of any frameworks and/or practices that exist which streamline work and create efficiency and consistency in accreditation practices?
10. For Specialist Medical Colleges – In 2012 the Australian Health Ministers Advisory Council (AHMAC) led a project, *Accreditation of Specialist Medical Training Sites* in consultation with the colleges and the Council of Presidents of Medical Colleges. Has this project informed any decisions around college accreditation frameworks and practices?
11. How often does the accreditation committee meet? Is this aligned with particular times / events of the year?
12. Who are your accreditation committee members? Do these members vary for sub-specialties?
13. If a training post, health setting or network is not recommended or approved for accreditation, what happens next? Does the college support the applicant for training post accreditation to meet accreditation standards and requirements? How?
14. When accreditation issues are raised or reported, what action/s does the college take?
15. What factors can result in a training post / health setting or network losing accreditation?

16. What are the threshold factors for accreditation?
17. Is there flexibility in the accreditation cycle / process to be responsive to identified training needs?
18. Is logbook data sufficient evidence to determine accreditation recommendations and outcomes?
19. How does the College ensure balanced, considered and objective accreditation assessments, recommendations and outcomes?
20. Do periods of rotations vary depending on post, health setting or network?
21. Are barriers to accreditation varied according to sub-specialty (for colleges that have sub-specialties)? How?
22. Who determines rotations? Supervisors, DoTs, Committees, etc.
23. Is post performance and efficacy of training in a post, health setting / network part of the evaluation?
24. Does the college have unaccredited posts? If so, are these linked to accredited posts? How do these posts contribute to building a specialist medical workforce?
25. Have there been situations whereby everything aligned to accredit a post / site / network and then at final approval stage accreditation was not approved or support? Explain.
26. Is the distribution of specialty training on the college Board's agenda/strategic plan? If so, explain. If not, why not?
27. What is the college's view on accreditation being an enabler for the improved distribution of your specialist medical workforce?
28. Is there an option for remote supervision or supervision by someone who is not a fellow of the college?
29. When training positions are part of a training network, what guarantees are there for all training posts within a network to be filled? i.e. if there are not enough trainees and there is a rank to filling the posts from largest health service to smallest – how do you ensure the smallest site doesn't miss out?

Face to Face Consultation Questions – ACD

1. What are the challenges within the current specialist medical college accreditation frameworks in terms of how accreditation impacts on the development of non-metropolitan specialist training pathways? What is the biggest challenge impacting your college?
2. What elements of the current specialist medical college accreditation frameworks are working well? What are the key components that are critical to maintaining quality training and patient safety that need to be maintained into the future?
3. How could specialist medical college accreditations frameworks be improved for better geographical distribution of specialist medical training?
4. Is the distribution of specialty training on the college Board's agenda/strategic plan?
5. What is the college's view on accreditation potentially being an enabler for the improved distribution of the specialist medical workforce?
6. What audit and quality improvement processes of accreditation activities are in place? For example to deliver change such as: flexibility, streamlining, innovation, collaboration, simplification and improved transparency?



Appendices

7. How do you think your college can contribute to delivering more high quality regionally based medical specialist training, within the existing accreditation system?
8. In 2012 the Australian Health Ministers Advisory Council (AHMAC) led a project, Accreditation of Specialist Medical Training Sites in consultation with the colleges and the Council of Presidents of Medical Colleges. Has this project informed any decisions around college accreditation frameworks and practices?
9. How often does the accreditation committee meet? Is this aligned with particular times / events of the year?
10. How do you determine accreditation committee members? Does membership vary depending on sub-specialty (where applicable)?
11. Do you have examples of potential new rural training posts, health settings or networks that were supported locally by health settings, college Fellows, supervisors and then not supported by the college accreditation committee?
12. If a training post, health setting or network is not recommended or approved for accreditation, what happens next? Does the college support the applicant for accreditation to meet accreditation standards and requirements? How?
13. When accreditation issues are raised or reported, what action/s does the college take?
14. What factors can result in a training post / health setting or network losing accreditation?
15. Is there flexibility in the accreditation cycle / process to be responsive to identified training needs?
16. Is logbook data sufficient evidence to inform accreditation recommendations and outcomes (if applicable)?
17. How does the College ensure balanced, considered, objective and consistent accreditation assessments, recommendations and outcomes?
18. Do periods of rotations vary depending on post, health setting or network? Who determines rotations? Supervisors, Directors of Training, Committees, etc.
19. Are barriers to accreditation varied according to sub-specialty (if applicable)? How?
20. Is post performance and efficacy of training in a post, health setting / network assessed or reviewed as part of a specialty training program evaluation?
21. Is there an option for a remote supervision model or supervision by someone who is not a fellow of the college?
22. When training positions are part of a training network, what guarantees are there for all training posts within a network to be filled? i.e. if there are not enough trainees and there is a rank to filling the posts from largest health service to smallest (or metro to rural) – how does the college ensure the smallest (or rural) site doesn't miss out?

Face to Face Consultation Questions – ACEM

1. What are the challenges within the current college accreditation framework in terms of how accreditation impacts on the development of non-metropolitan (rural) specialist training pathways? What is the biggest challenge impacting your college?
2. What elements of the current specialist medical college accreditation frameworks are working well? What are the key components that are critical to maintaining quality training and patient safety that need to be maintained into the future?
3. How could specialist medical college accreditation frameworks be improved for better geographical distribution of specialist medical training?
4. Is the distribution of specialty training on the college Board's agenda/strategic plan?
5. What is the college's view on accreditation potentially being an enabler for the improved distribution of the specialist medical workforce?
6. What audit and quality improvement processes of accreditation activities are in place? For example to deliver change such as: flexibility, streamlining, innovation, collaboration, simplification and improved transparency?
7. How do you think your college can contribute to delivering more high quality regionally based medical specialist training, within the existing accreditation system?
8. In 2012 the Australian Health Ministers Advisory Council (AHMAC) led a project, Accreditation of Specialist Medical Training Sites in consultation with the colleges and the Council of Presidents of Medical Colleges. Has this project informed any decisions around college accreditation frameworks and practices?
9. How often does the accreditation committee meet? Is this aligned with particular times / events of the year?
10. How do you determine accreditation committee members?
11. Do you have examples of potential new rural training posts, health settings or networks that were supported locally by health settings, college Fellows, supervisors and then not supported by the college accreditation committee?
12. If a training post, health setting or network is not recommended or approved for accreditation, what happens next? Does the college support the applicant for accreditation to meet accreditation standards and requirements? How?
13. When accreditation issues are raised or reported, what action/s does the college take?
14. What factors can result in a training post / health setting or network losing accreditation?
15. Is there flexibility in the accreditation cycle / process to be responsive to identified training needs?
16. How does the College ensure balanced, considered, objective and consistent accreditation assessments, recommendations and outcomes?
17. Do periods of rotations vary depending on post, health setting or network? Who determines rotations? Supervisors, Directors of Training, Committees, etc.
18. Is post performance and efficacy of training in a post, health setting / network assessed or reviewed as part of a specialty training program evaluation?
19. Is there an option for a remote supervision model or supervision by someone who is not a fellow of the college?
20. When training positions are part of a training network, what guarantees are there for all training posts within a network to be filled? i.e. if there are not enough trainees and there is a rank to filling the posts from largest health service to smallest (or metro to rural) – how does the college ensure the smallest (or rural) site doesn't miss out?



Appendices

Face to Face Consultation Questions – ANZCA

1. What are the challenges within your current accreditation framework in terms of how accreditation impacts on the development of non-metropolitan (rural) specialist training pathways? What is the biggest challenge impacting your college?
2. How frequently does the college review the accreditation framework?
3. What changes in accreditation have evolved over time for your college to better meet the needs of trainees, supervisors and health settings in specialty training?
4. What elements of the current specialist medical college accreditation frameworks are working well? What are the key components that are critical to maintaining quality training and patient safety that need to be maintained into the future?
5. Please identify influences that impact on the location and geographical distribution of specialty training for your college? Is community need a consideration?
6. How could specialist medical college accreditation frameworks be improved for better geographical distribution of specialist medical training?
7. Is the distribution of specialty training on the college Board's agenda/strategic plan?
8. What is the college's view on accreditation potentially being an enabler for the improved distribution of the specialist medical workforce?
9. What audit and quality improvement processes of accreditation activities are in place? For example to deliver change such as: flexibility, streamlining, innovation, collaboration, simplification and improved transparency?
10. How do you think your college can contribute to delivering more high quality regionally based medical specialist training, within the existing accreditation system?
11. In 2012 the Australian Health Ministers Advisory Council (AHMAC) led a project, Accreditation of Specialist Medical Training Sites in consultation with the colleges and the Council of Presidents of Medical Colleges. Has this project informed any decisions around college accreditation frameworks and practices?
12. How often does the accreditation committee meet? Is this aligned with particular times / events of the year?
13. How do you determine accreditation committee members?
14. Do you have examples of potential new rural training posts, health settings or networks that were supported locally by health settings, college Fellows, supervisors and then not supported by the college accreditation committee?
15. If a training post, health setting or network is not recommended or approved for accreditation, what happens next? Does the college support the applicant for accreditation to meet accreditation standards and requirements? How?
16. When accreditation issues are raised or reported, what action/s does the college take?
17. What factors can result in a training post / health setting or network losing accreditation? What factors would require re-accreditation?
18. Is there flexibility in the accreditation cycle / process to be responsive to identified training needs?
19. Is logbook data sufficient evidence to inform accreditation recommendations and outcomes (if applicable)?
20. How does the College ensure balanced, considered, objective and consistent accreditation assessments, recommendations and outcomes?

21. Do periods of rotations vary depending on post, health setting or network? Who determines rotations? Supervisors, Directors of Training, Committees, etc.
22. Are barriers to accreditation varied according to sub-specialty (if applicable)? How?
23. Is post performance and efficacy of training in a post, health setting / network assessed or reviewed as part of a specialty training program evaluation?
24. Is there an option for a remote supervision model or supervision by someone who is not a fellow of the college?
25. When training positions are part of a training network, what guarantees are there for all training posts within a network to be filled? i.e. if there are not enough trainees and there is a rank to filling the posts from largest health service to smallest (or metro to rural) – how does the college ensure the smallest (or rural) site doesn't miss out?

Face to Face Consultation Questions – CICM

1. What are the challenges within your current specialist medical college accreditation framework in terms of how accreditation impacts on the development of non-metropolitan (rural) specialist training pathways? What is the biggest challenge impacting your college?
2. What elements of the current specialist medical college accreditation frameworks are working well? What are the key components that are critical to maintaining quality training and patient safety that need to be retained into the future?
3. How could specialist medical college accreditation frameworks be improved for better geographical distribution of specialist medical training?
4. How do you think your college can contribute to delivering more high quality regionally based medical specialist training, within the existing accreditation system?
5. Is the distribution of specialty training on the college Board's agenda/strategic plan?
6. What is the college's view on accreditation potentially being an enabler for the improved distribution of the specialist medical workforce?
7. What audit and quality improvement processes of accreditation activities are in place? For example to deliver change such as: flexibility, streamlining, innovation, collaboration, simplification and improved transparency?
8. In 2012 the Australian Health Ministers Advisory Council (AHMAC) led a project, *Accreditation of Specialist Medical Training Sites* in consultation with the colleges and the Council of Presidents of Medical Colleges. Has this project informed any decisions around college accreditation frameworks and practices?
9. How often does the accreditation committee meet? Is this aligned with particular times / events of the year?
10. How do you determine accreditation committee members?
11. Do you have examples of potential new rural training posts, health settings or networks that were supported locally by health settings, college Fellows, supervisors and then not supported by the college accreditation committee?
12. If a training post, health setting or network is not recommended or approved for accreditation, what happens next? Does the college support the applicant for accreditation to meet accreditation standards and requirements? How?



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13. When accreditation issues are raised or reported, what action/s does the college take?
14. What factors can result in a training post, health setting or network losing accreditation?
15. Is there flexibility in the accreditation cycle / process to be responsive to identified training needs?
16. How does the college ensure balanced, considered, objective and consistent accreditation assessments, recommendations and outcomes?
17. Do periods of rotations vary depending on a training post, health setting or network? Who determines rotations? Supervisors, Directors of Training, Committees, etc.
18. Is post performance and efficacy of training in a post, health setting or network assessed or reviewed as part of a specialty training program evaluation?
19. Is there an option for a remote supervision model or supervision by someone who is not a fellow of the college?
20. When training positions are part of a training network, what guarantees are there for all training posts within a network to be filled? i.e. if there are not enough trainees and there is a rank to filling the posts from largest health service to smallest (or metro to rural) – how does the college ensure the smallest (or rural) site doesn't miss out?

Face to Face Consultation Questions – RACP

1. What are the challenges within the current college accreditation framework in terms of how accreditation impacts on the development of non-metropolitan (rural) specialist training pathways? What is the biggest challenge impacting your college and the subspecialties?
2. What elements of the current specialist medical college accreditation frameworks are working well? What are the key components that are critical to maintaining quality training and patient safety that need to be maintained into the future?
3. How could specialist medical college accreditation frameworks be improved for better geographical distribution of specialist medical training?
4. How do you think your college and subspecialties can contribute to delivering more high quality regionally based medical specialist training within the structure of an accreditation system?
5. Is the distribution of specialty training on the College Board's agenda/strategic plan?
6. What is your view on accreditation potentially being an enabler for the improved distribution of the specialist medical workforce for physicians? Is this different per subspecialty?
7. What audit and quality improvement processes of accreditation activities are in place? For example to deliver change such as: flexibility, streamlining, innovation, collaboration, simplification and improved transparency? Do you evaluate performance of the college and/or subspecialties undertaking accreditation?
8. In 2012 the Australian Health Ministers Advisory Council (AHMAC) led a project, Accreditation of Specialist Medical Training Sites in consultation with the colleges and the Council of Presidents of Medical Colleges. Has this project informed any decisions around college accreditation frameworks and practices?
9. When the College Education Committee (CEC) meets, are meetings aligned with particular times / events of the year? Is accreditation an item on every meeting agenda?

10. Do you have examples of potential new rural training posts, health settings or networks that were supported locally by health settings, college Fellows, supervisors and then not supported by the RACP Training Committee or CEC?
11. If a training post, health setting or network is not recommended or approved for accreditation, what happens next? Does the college and/or the RACP training committee for and/or subspecialties undertaking accreditation?
12. In 2012 the Australian Health Ministers Advisory Council (AHMAC) led a project, Accreditation of Specialist Medical Training Sites in consultation with the colleges and the Council of Presidents of Medical Colleges. Has this project informed any decisions around college accreditation frameworks and practices?
13. When the College Education Committee (CEC) meets, are meetings aligned with particular times / events of the year? Is accreditation an item on every meeting agenda?
14. Do and/or subspecialties undertaking accreditation?
15. In 2012 the Australian Health Ministers Advisory Council (AHMAC) led a project, Accreditation of Specialist Medical Training Sites in consultation with the colleges and the Council of Presidents of Medical Colleges. Has this project informed any decisions around college accreditation frameworks and practices?
16. When the College Education Committee (CEC) meets, are meetings aligned with particular times / events of the year? Is accreditation an item on every meeting agenda?
17. Do you have examples of potential new rural training posts, health settings or networks and/or subspecialties undertaking accreditation?
18. In 2012 the Australian Health Ministers Advisory Council (AHMAC) led a project, Accreditation of Specialist Medical Training Sites in consultation with the colleges and the Council of Presidents of Medical Colleges. Has this project informed any decisions around college accreditation frameworks and practices?
19. When the College Education Committee (CEC) meets, are meetings aligned with particular times / events of the year? Is accreditation an item on every meeting agenda?
20. Do you have examples of potential new rural training posts, health settings or networks that were supported locally by health settings, college Fellows, supervisors and then not supported by the RACP Training Committee or CEC? And/or subspecialties undertaking accreditation?
21. In 2012 the Australian Health Ministers Advisory Council (AHMAC) led a project, Accreditation of Specialist Medical Training Sites in consultation with the colleges and the Council of Presidents of Medical Colleges. Has this project informed any decisions around college accreditation frameworks and practices?
22. When the College Education Committee (CEC) meets, are meetings aligned with particular times / events of the year? Is accreditation an item on every meeting agenda?
23. Do you have examples of potential new rural training posts, health settings or networks that were supported locally by health settings, college Fellows, supervisors and then not supported by the RACP Training Committee or CEC?



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Face to Face Consultation Questions – RACS

1. What are the challenges within the current college (RACS) accreditation framework in terms of how accreditation impacts on the development of non-metropolitan (rural) specialist training pathways? What is the biggest challenge impacting your college and the surgical specialties?
2. What elements of the current specialist medical college accreditation frameworks are working well? What are the key components that are critical to maintaining quality training and patient safety that need to be maintained into the future?
3. How could specialist medical college accreditation frameworks be improved for better geographical distribution of specialist medical training?
4. How do you think your college and specialties can contribute to delivering more high quality regionally based medical specialist training, within the existing accreditation system?
5. Is the distribution of specialty training on the College Council's agenda/strategic plan?
6. What is your view on accreditation potentially being an enabler for the improved distribution of the specialist medical workforce for surgery?
7. What audit and quality improvement processes of accreditation activities are in place? For example to deliver change such as: flexibility, streamlining, innovation, collaboration, simplification and improved transparency? Do you evaluate performance of the college and/or specialties undertaking accreditation?
8. In 2012 the Australian Health Ministers Advisory Council (AHMAC) led a project, *Accreditation of Specialist Medical Training Sites* in consultation with the colleges and the Council of Presidents of Medical Colleges. Has this project informed any decisions around college accreditation frameworks and practices?
9. When the Board of Surgical Education and Training meets, are meetings aligned with particular times / events of the year? Is accreditation an item on every meeting agenda?
10. Do you have examples of potential new rural training posts, health settings or networks that were supported locally by health settings, college Fellows, supervisors and then not supported by BSET?
11. If a training post, health setting or network is not recommended or approved for accreditation, what happens next? Does the college and/or the specialty support the applicant for accreditation to meet accreditation standards and requirements? How?
12. When accreditation issues are raised or reported, what action/s does the college (RACS) and / or the specialty take?
13. What factors can result in a training post, health setting or network losing accreditation?
14. Is there flexibility in the accreditation cycle / process to be responsive to training and trainee needs? Government programs?
15. Is logbook data sufficient evidence to inform accreditation recommendations and outcomes? What other evidence is required? Are evidence requirements clearly articulated for health settings to achieve?
16. How does the college and specialties ensure balanced, considered, objective and consistent accreditation assessments, recommendations and outcomes?
17. Do periods of rotations vary depending on post, health setting or network? Who determines rotations? Supervisors, Directors of Training, Committees, etc.
18. Is post performance and efficacy of training in a post, health setting / network assessed or reviewed as part of a specialty training program evaluation?

19. Are there service registrar (unaccredited) posts in surgery? If so, are these linked to accredited posts? Is RPL awarded to those registrars when they apply to join a program? How do these posts contribute to building a specialist medical workforce?
20. Is there an option for a remote supervision model or supervision by someone who is not a fellow of the college or a specialty member?
21. When training positions are part of a training network, what guarantees are there for all training posts within a network to be filled? i.e. if there are not enough trainees and there is a rank to filling the posts from largest health service to smallest (or metro to rural) – how does the college ensure the smallest (or rural) site doesn't miss out?

Face to Face Consultation Questions – RACS AOA

1. What are the challenges within the current college (RACS) accreditation framework in terms of how accreditation impacts on the development of non-metropolitan (rural) specialist training pathways? What is the biggest challenge impacting your specialty or college?
2. What elements of the current specialist medical college accreditation frameworks are working well? What are the key components that are critical to maintaining quality training and patient safety that need to be maintained into the future?
3. How could specialist medical college accreditation frameworks be improved for better geographical distribution of specialist medical training?
4. Is the distribution of specialty training on the Board of Director's agenda/strategic plan?
5. What is your view on accreditation potentially being an enabler for the improved distribution of the specialist medical workforce?
6. What audit and quality improvement processes of accreditation activities are in place? For example to deliver change such as: flexibility, streamlining, innovation, collaboration, simplification and improved transparency?
7. How do you think your college and specialty can contribute to delivering more high quality regionally based medical specialist training, within the existing accreditation system?
8. In 2012 the Australian Health Ministers Advisory Council (AHMAC) led a project, Accreditation of Specialist Medical Training Sites in consultation with the colleges and the Council of Presidents of Medical Colleges. Has this project informed any decisions around college accreditation frameworks and practices?
9. How often does the accreditation committee meet? Is this aligned with particular times / events of the year?
10. Do you have examples of potential new rural training posts, health settings or regional networks that were supported locally by health settings, college Fellows / society members, supervisors and by the AOA then not supported by the Board of Surgical Education and Training (BSET)?
11. If a training post, health setting or network is not recommended or approved for accreditation, what happens next? Does the college and/or the specialty support the applicant for accreditation to meet accreditation standards and requirements? How?
12. When accreditation issues are raised or reported, what action/s does the college (RACS) and the specialty take?
13. What factors can result in a training post / health setting or network losing accreditation?
14. Is there flexibility in the accreditation cycle / process to be responsive to identified training needs?



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15. Is logbook data sufficient evidence to inform accreditation recommendations and outcomes?
16. How does the college and specialty ensure balanced, considered, objective and consistent accreditation assessments, recommendations and outcomes?
17. Do periods of rotations vary depending on post, health setting or regional network? Who determines rotations? Supervisors, Directors of Training, Committees, etc.
18. Is post performance and efficacy of training in a post, health setting or regional network assessed or reviewed as part of a specialty training program evaluation?
19. Is there an option for a remote supervision model or supervision by someone who is not a fellow of the college or a society member?
20. When training positions are part of a training regional network, what guarantees are there for all training posts within a network to be filled? i.e. if there are not enough trainees and there is a rank to filling the posts from largest health service to smallest (or metro to rural) – how does the specialty ensure the smallest (or rural) site doesn't miss out?

Face to Face Consultation Questions – RACS NSA

1. What are the challenges within the current college (RACS) accreditation framework in terms of how accreditation impacts on the development of non-metropolitan (rural) specialist training pathways? What is the biggest challenge impacting your college, specialty or sub-specialty?
2. What elements of the current specialist medical college accreditation frameworks are working well? What are the key components that are critical to maintaining quality training and patient safety that need to be maintained into the future?
3. How could specialist medical college accreditation frameworks be improved for better geographical distribution of specialist medical training?
4. Is the distribution of specialty training on the Board of Management's agenda/strategic plan?
5. What is your view on accreditation potentially being an enabler for the improved distribution of the specialist medical workforce?
6. What audit and quality improvement processes of accreditation activities are in place? For example to deliver change such as: flexibility, streamlining, innovation, collaboration, simplification and improved transparency?
7. How do you think your college and specialty can contribute to delivering more high quality regionally based medical specialist training, within the existing accreditation system?
8. In 2012 the Australian Health Ministers Advisory Council (AHMAC) led a project, Accreditation of Specialist Medical Training Sites in consultation with the colleges and the Council of Presidents of Medical Colleges. Has this project informed any decisions around college accreditation frameworks and practices?
9. How often does the accreditation committee meet? Is this aligned with particular times / events of the year?
10. How do you determine accreditation committee members?

11. Do you have examples of potential new rural training posts, health settings or networks that were supported locally by health settings, college Fellows, supervisors and then not supported by the college accreditation committee?
12. If a training post, health setting or network is not recommended or approved for accreditation, what happens next? Does the college and/ or the specialty support the applicant for accreditation to meet accreditation standards and requirements? How?
13. When accreditation issues are raised or reported, what action/s does the college (RACS) and the specialty take?
14. What factors can result in a training post / health setting or network losing accreditation?
15. Is there flexibility in the accreditation cycle / process to be responsive to identified training needs?
16. Is logbook data sufficient evidence to inform accreditation recommendations and outcomes (if applicable)?
17. How does the college and specialty ensure balanced, considered, objective and consistent accreditation assessments, recommendations and outcomes?
18. Do periods of rotations vary depending on post, health setting or network? Who determines rotations? Supervisors, Directors of Training, Committees, etc.
19. Is post performance and efficacy of training in a post, health setting / network assessed or reviewed as part of a specialty training program evaluation?
20. Is there an option for a remote supervision model or supervision by someone who is not a fellow of the college or a society member?
21. When training positions are part of a training network, what guarantees are there for all training posts within a network to be filled? i.e. if there are not enough trainees and there is a rank to filling the posts from largest health service to smallest (or metro to rural) – how does the college ensure the smallest (or rural) site doesn't miss out?

Face to Face Consultation Questions – RACMA

1. What are the challenges (if any) within your current specialist medical college accreditation framework in terms of how accreditation impacts on the development of non-metropolitan (rural) specialist training pathways? What is the biggest challenge impacting RACMA?
2. What elements of the current specialist medical college accreditation frameworks are working well? What are the key components that are critical to maintaining quality training and patient safety that need to be retained into the future?
3. How could specialist medical college accreditations frameworks be improved for better geographical distribution of specialist medical training?
4. How do you think your college can contribute to delivering more high quality regionally based medical specialist training, within the existing accreditation system?
5. Is the distribution of specialty medical administration training on the college Board's agenda/strategic plan?
6. What is the college's view on accreditation potentially being an enabler for the improved distribution of the specialist medical workforce?
7. What audit and quality improvement processes of accreditation activities are in place? For example to deliver change such as: flexibility, streamlining, innovation, collaboration, simplification and improved transparency?



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8. In 2012 the Australian Health Ministers Advisory Council (AHMAC) led a project, Accreditation of Specialist Medical Training Sites in consultation with the colleges and the Council of Presidents of Medical Colleges. Has this project informed any decisions around college accreditation frameworks and practices?
9. How often does the accreditation committee meet? Is this aligned with particular training milestones or events during the year?
10. How are accreditation committee members determined? Is rural representation present on the accreditation committee? Is rural representation present on accreditation panels that go out to rural accreditation visits?
11. Do you have examples of potential new rural training posts that were supported locally by health settings, college Fellows, supervisors and then not supported by the college accreditation committee?
12. If a training post is not recommended or approved for accreditation, what happens next? Does the college support the applicant for accreditation to meet accreditation standards and requirements? How?
13. When accreditation issues are raised or reported, what action/s does the college take?
14. What factors can result in a training post losing accreditation?
15. Is there flexibility in the accreditation cycle / process to be responsive to identified training needs?
16. How does the College ensure balanced, considered, objective and consistent accreditation assessments, recommendations and outcomes?
17. Do periods of rotations vary depending on the training post? Who determines rotations? Supervisors, Directors of Training, Committees, etc.
18. Are barriers to accreditation varied according to jurisdiction or region? How?
19. Is post performance and efficacy of training in a post or health setting assessed or reviewed as part of a specialty training program evaluation?
20. Is there an option for a remote supervision model or supervision by someone who is not a fellow of the college?

Face to Face Consultation Questions – RANZCOG

1. What are the challenges within the current college (RANZCOG) accreditation framework in terms of how accreditation impacts on the development of non-metropolitan (rural) specialist training pathways? What is the biggest challenge impacting your college?
2. What elements of the current specialist medical college accreditation frameworks are working well? What are the key components that are critical to maintaining quality training and patient safety that need to be maintained into the future?
3. How could specialist medical college accreditation frameworks be improved for better geographical distribution of specialist medical training?
4. How do you think your college can contribute to delivering more high quality regionally based specialist medical training within the structure of an accreditation system?
5. Is the distribution of specialty training on the College Board's agenda/strategic plan?
6. What is your view on accreditation potentially being an enabler for the improved distribution of the specialist medical workforce?

7. What audit and quality improvement processes of accreditation activities are in place? For example to deliver change such as: flexibility, streamlining, innovation, collaboration, simplification and improved transparency? Do you evaluate performance of the college and/or state / NZ accreditation committees undertaking accreditation on behalf of the college?
8. In 2012 the Australian Health Ministers Advisory Council (AHMAC) led a project, Accreditation of Specialist Medical Training Sites in consultation with the colleges and the Council of Presidents of Medical Colleges. Has this project informed any decisions around college accreditation frameworks and practices?
9. Are Training Accreditation Committee (TAC) meetings aligned with particular times / events of the year? Is accreditation of sites an item on every meeting agenda?
10. Do you have examples of potential new rural training posts, health settings or networks that were supported locally by health settings, college Fellows, supervisors and then not supported by the State / NZ Accreditation Committees or Training Accreditation Committee?
11. If a training post, health setting or network is not recommended or approved for accreditation, what happens next? Does the college and/or the support the applicant for accreditation to meet accreditation standards and requirements? How?
12. When accreditation issues are raised or reported, what action/s does the college and / or the State/NZ training accreditation committees take?
13. What factors can result in a training post, health setting or network losing accreditation?
14. Is there flexibility in the accreditation cycle / process to be responsive to training and trainee needs? Government programs?
15. How is logbook data used? Is logbook data sufficient evidence to inform accreditation recommendations and outcomes? What other evidence is required? Are evidence requirements clearly articulated for health settings to achieve?
16. How does the college and accreditation committees ensure balanced, considered, objective and consistent accreditation assessments, recommendations and outcomes?
17. Do periods of rotations vary depending on post, health setting or network? Who determines rotations? Supervisors, Directors of Training, Committees, etc.
18. Is post performance and efficacy of training in a post, health setting or network assessed or reviewed as part of specialty training program evaluation?
19. Are there service registrar (unaccredited) posts for O&G? If so, are these linked to accredited posts? Is RPL awarded to those registrars when they apply to join a program? How do these posts contribute to building a specialist medical workforce?
20. Is there an option for a remote supervision model or supervision by someone who is not a fellow of the college?
21. When training positions are part of a training network, what guarantees are there for all training posts within a network to be filled? i.e. if there are not enough trainees and there is a rank to filling the posts from largest health service to smallest (or metro to rural) – how does the college and /or jurisdictional committees ensure the smallest (or rural) site doesn't miss out?



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Face to Face Consultation Questions – RANZCO

1. What are the challenges within the current specialist medical college accreditation frameworks in terms of how accreditation impacts on the development of non-metropolitan specialist training pathways? What is the biggest challenge impacting your college?
2. What elements of the current specialist medical college accreditation frameworks are working well? What are the key components that are critical to maintaining quality training and patient safety that need to be maintained into the future?
3. How could specialist medical college accreditations frameworks be improved for better geographical distribution of specialist medical training?
4. Is the distribution of specialty training on the college Board's agenda/strategic plan?
5. What is the college's view on accreditation potentially being an enabler for the improved distribution of the specialist medical workforce?
6. What audit and quality improvement processes of accreditation activities are in place? For example to deliver change such as: flexibility, streamlining, innovation, collaboration, simplification and improved transparency?
7. How do you think your college can contribute to delivering more high quality regionally based medical specialist training, within the existing accreditation system?
8. In 2012 the Australian Health Ministers Advisory Council (AHMAC) led a project, *Accreditation of Specialist Medical Training Sites* in consultation with the colleges and the Council of Presidents of Medical Colleges. Has this project informed any decisions around college accreditation frameworks and practices?
9. How often does the accreditation committee meet? Is this aligned with particular times / events of the year?
10. How do you determine accreditation committee members? Does membership vary depending on sub-specialty (where applicable)?
11. Do you have examples of potential new rural training posts, health settings or networks that were supported locally by health settings, college Fellows, supervisors and then not supported by the college accreditation committee?
12. If a training post, health setting or network is not recommended or approved for accreditation, what happens next? Does the college support the applicant for accreditation to meet accreditation standards and requirements? How?
13. When accreditation issues are raised or reported, what action/s does the college take?
14. What factors can result in a training post / health setting or network losing accreditation?
15. Is there flexibility in the accreditation cycle / process to be responsive to identified training needs?
16. Is logbook data sufficient evidence to inform accreditation recommendations and outcomes (if applicable)?
17. How does the College ensure balanced, considered, objective and consistent accreditation assessments, recommendations and outcomes?
18. Do periods of rotations vary depending on post, health setting or network? Who determines rotations? Supervisors, Directors of Training, Committees, etc.
19. Are barriers to accreditation varied according to sub-specialty (if applicable)? How?
20. Is post performance and efficacy of training in a post, health setting / network assessed or reviewed as part of a specialty training program evaluation?

21. Is there an option for a remote supervision model or supervision by someone who is not a fellow of the college?

22. When training positions are part of a training network, what guarantees are there for all training posts within a network to be filled? i.e. if there are not enough trainees and there is a rank to filling the posts from largest health service to smallest (or metro to rural) – how does the college ensure the smallest (or rural) site doesn't miss out?

Face to Face Consultation Questions – RANZCP

1. What are the challenges within your current specialist medical college accreditation framework in terms of how accreditation impacts on the development of non-metropolitan (rural) specialist training pathways? What is the biggest challenge impacting your college?
2. What elements of the current specialist medical college accreditation frameworks are working well? What are the key components that are critical to maintaining quality training and patient safety that need to be maintained into the future?
3. How could specialist medical college accreditation frameworks be improved for better geographical distribution of specialist medical training?
4. Is the distribution of specialty training on the college Board's agenda/strategic plan?
5. What is the college's view on accreditation potentially being an enabler for the improved distribution of the specialist medical workforce?
6. What audit and quality improvement processes of accreditation activities are in place? For example to deliver change such as: flexibility, streamlining, innovation, collaboration, simplification and improved transparency?
7. How do you think your college can contribute to delivering more high quality regionally based medical specialist training, within the existing accreditation system?
8. In 2012 the Australian Health Ministers Advisory Council (AHMAC) led a project, Accreditation of Specialist Medical Training Sites in consultation with the colleges and the Council of Presidents of Medical Colleges. Has this project informed any decisions around college accreditation frameworks and practices?
9. How often does the accreditation committee meet? Is this aligned with particular times / events of the year?
10. How do you determine accreditation committee members?
11. Do you have examples of potential new rural training posts or programs that were supported locally by health settings, college Fellows, supervisors and then not supported by the college accreditation committee?
12. If a training post or program is not recommended or approved for accreditation, what happens next? Does the college support the applicant for accreditation to meet accreditation standards and requirements? How?
13. When accreditation issues are raised or reported, what action/s does the college take?
14. What factors can result in a training post or program losing accreditation?
15. Is there flexibility in the accreditation cycle / process to be responsive to identified training needs?



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16. How does the College ensure balanced, considered, objective and consistent accreditation assessments, recommendations and outcomes?
17. Do periods of rotations vary depending on post, program or health setting? Who determines rotations? Supervisors, Directors of Training, Committees, etc.
18. Is post performance and efficacy of training in a post, health setting / network assessed or reviewed as part of a specialty training program evaluation?
19. Is there an option for a remote supervision model or supervision by someone who is not a fellow of the college?
20. When training positions are part of a training network including metropolitan health settings, what guarantees are there for all training posts within a network to be filled? i.e. if there are not enough trainees and there is a rank to filling the posts from largest health service to smallest (or metro to rural) – how does the college ensure the smallest (or rural) site doesn't miss out?

Face to Face Consultation Questions – RANZCR

1. What are the challenges within your current specialist medical college accreditation frameworks (Clinical Radiology and Radiation Oncology) in terms of how accreditation impacts on the development of non-metropolitan (rural) specialist training pathways? What is the biggest challenge impacting your college and faculties?
2. What elements of the current specialist medical college accreditation frameworks are working well? What are the key components that are critical to maintaining quality training and patient safety that need to be maintained into the future?
3. How could specialist medical college accreditation frameworks be improved for better geographical distribution of specialist medical training?
4. Is the distribution of specialty training on the college Board of Directors' agenda/Strategic Plan? Is this aligned with Strategic Priority 3, Action Area 3.3 and Strategic Priority 4 – Clinical Excellence?
5. What is the college's view on accreditation potentially being an enabler for the improved distribution of the specialist medical workforce?
6. What audit and quality improvement processes of accreditation activities are in place? For example to deliver change such as: flexibility, streamlining, innovation, collaboration, simplification and improved transparency?
7. How do you think your college and the faculties can contribute to delivering more high quality regionally based medical specialist training, within the existing accreditation system?
8. In 2012 the Australian Health Ministers Advisory Council (AHMAC) led a project, Accreditation of Specialist Medical Training Sites in consultation with the colleges and the Council of Presidents of Medical Colleges. Has this project informed any decisions around college accreditation frameworks and practices?
9. How often do the faculty Education and Training committees meet? Is this aligned with particular times / events of the year?
10. How do you determine accreditation members of the Clinical Radiology Education and Training Committee (CRET) and Radiation Oncology Education and Training Committee (ROETC)? Does membership vary depending faculty?
11. Do you have local jurisdictional health department representatives involved in accreditation?

12. Do you have examples of potential new rural training posts, health settings or networks that were supported locally by health settings, college Fellows, supervisors and then not supported by the faculty ETCs?
13. If a training post, health setting or network is not recommended or approved for accreditation, what happens next? Does the college and /or do the faculties support the applicant for accreditation to meet accreditation standards and requirements? How?
14. When accreditation issues are raised or reported, what action/s does the college and faculties take?
15. What factors can result in a training post, health setting or network losing accreditation?
16. Is there flexibility in the accreditation cycle / process to be responsive to identified training needs?
17. How does the college and faculties ensure balanced, considered, objective and consistent accreditation assessments, recommendations and outcomes?
18. Are barriers to accreditation varied according to faculty? How?
19. Rural/regional rotations have been identified as a component of your Network Accreditation model. Can you please provide further information on this model?
20. Is post performance and efficacy of training in a post, health setting or network assessed or reviewed as part of a specialty training program evaluation?
21. Is there an option for a remote supervision model or supervision by someone who is not a fellow of the college?
22. When training positions are part of a training network, what guarantees are there for all training posts within a network to be filled? i.e. if there are not enough trainees and there is a rank to filling the posts from largest health service to smallest (or metro to rural) – how does the college ensure the smallest (or rural) site doesn't miss out?

Face to Face Consultation Questions – RCPA

1. What are the challenges within your current college accreditation framework in terms of how accreditation impacts on the development of non-metropolitan (rural) specialist training pathways? What is the biggest challenge impacting your college?
2. What elements of the current specialist medical college accreditation frameworks are working well? What are the key components that are critical to maintaining quality training and patient safety that need to be maintained into the future?
3. How could specialist medical college accreditation frameworks be improved for better geographical distribution of specialist medical training?
4. Is the distribution of specialty training on the college Board's agenda/strategic plan?
5. What is the college's view on accreditation potentially being an enabler for the improved distribution of the specialist medical workforce?
6. What audit and quality improvement processes of accreditation activities are in place? For example to deliver change such as: flexibility, streamlining, innovation, collaboration, simplification and improved transparency?
7. How do you think your college can contribute to delivering more high quality regionally based medical specialist training, within the existing accreditation system?



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8. In 2012 the Australian Health Ministers Advisory Council (AHMAC) led a project, Accreditation of Specialist Medical Training Sites in consultation with the colleges and the Council of Presidents of Medical Colleges. Has this project informed any decisions around college accreditation frameworks and practices?
9. How often does the Board of Education and Assessment (BEA) [accreditation committee] meet? Is this aligned with particular times / events of the year?
10. How do you determine BEA members? Does membership vary depending on sub-discipline?
11. Do you have examples of potential new rural training posts, medical laboratories or networks that were supported locally by health settings, college Fellows, supervisors and then not supported by the college BEA?
12. If a training post, medical laboratory or network is not recommended or approved for accreditation, what happens next? Does the college support the applicant for accreditation to meet accreditation standards and requirements? How?
13. When accreditation issues are raised or reported, what action/s does the college take?
14. What factors can result in a training post, site or network losing accreditation?
15. Is there flexibility in the accreditation cycle / process to be responsive to identified training needs?
16. Is logbook data sufficient evidence to inform accreditation recommendations and outcomes?
17. How does the College ensure balanced, considered, objective and consistent accreditation assessments, recommendations and outcomes?
18. Do periods of rotations vary depending on post, medical laboratory or network? Who determines rotations? Supervisors, Directors of Training, Committees, etc.
19. Are barriers to accreditation varied according to sub-discipline? How?
20. Is post performance and efficacy of training in a post, medical laboratory, network assessed or reviewed as part of a specialty training program evaluation?
21. Is there an option for a remote supervision model or supervision by someone who is not a fellow of the college?
22. When training positions are part of a training network, what guarantees are there for all training posts within a network to be filled? i.e. if there are not enough trainees and there is a rank to filling the posts from largest site to smallest (or metro to rural) – how does the college ensure the smallest (or rural) site doesn't miss out?

Appendix N2: States and Territories

Face to Face Consultation Questions

1. What do you think are the challenges within the current specialist medical college accreditation frameworks in terms of how accreditation impacts on the development of non-metropolitan specialist training pathways? What is the biggest challenge impacting your organisation?
2. What elements of the current specialist medical college accreditation frameworks are working well? What are the key components that are critical to maintaining quality training and patient safety that need to be maintained into the future?
3. How could specialist medical college accreditations frameworks be improved for better geographical distribution of specialist medical training and in specialities that communities need?
4. Do you have examples of new rural training sites successfully accredited and /or proposals that were not supported or need further work to meet the accreditation requirements?
5. How is accreditation data collected by your organisation, if at all? How is this data utilised?
6. How do you think your organisation can contribute to delivering more high quality regionally based medical specialist training, within the existing accreditation system?
7. How are government programs being used to support the creation of new rural medical specialist training sites? What programs are available apart from Commonwealth programs?
8. If your organisation is involved in accreditation activities across the medical education and training continuum (medical school, prevocational and vocational training) can you think of any frameworks and/or practices that exist which streamline work and create efficiency and consistency in accreditation practices?
9. How does your jurisdiction influence or impact specialist medical colleges in the accreditation of training posts / site / networks for specialist medical training?
10. What, if any, policies, strategies or programs have been developed to support the expansion of specialist training in rural and regional areas? (i.e. NSW – Metropolitan Access Scholarships for rural trainees to rotate to metro sites).



Appendix N3: Rural and Regional Hospitals and Health Services

Face to Face Consultation Questions

1. What do you think are the challenges within the current specialist medical college accreditation frameworks in terms of how accreditation impacts on the development of non-metropolitan (rural) specialist training pathways? What is the biggest challenge impacting your organisation or region?
2. What elements of the current specialist medical college accreditation frameworks are working well? What are the key components that are critical to maintaining quality training and patient safety that need to be maintained into the future?
3. How could specialist medical college accreditation frameworks be improved for better geographical distribution of specialist medical training and in specialities that communities need?
4. What are the key activities for your organisation during an accreditation process (pre-application, application, assessment and decision)? What resources are required and how long does each stage usually take?
5. Do you have examples of new rural training sites successfully accredited and /or proposals that were not supported or need further work to meet the accreditation requirements?
6. How do you think your organisation can contribute to delivering more high quality regionally based medical specialist training, within the existing accreditation system?
7. How are government programs being used by your organisation to support the creation of new rural medical specialist training sites? Which programs are you participating in apart from Commonwealth programs?
8. If your organisation is involved in accreditation activities across the medical education and training continuum (medical school, prevocational and vocational training) can you think of any frameworks and/or practices that exist which streamline work and create efficiency and consistency in accreditation practices?
9. How many specialty training posts / networks do you have active currently or is your organisation a part of? In which specialties (and sub-specialties) do you support training?
10. What barriers (if any) have you encountered in establishing / supporting the establishment of training posts / sites / networks with specialist medical colleges?
11. Are any accreditation conditions placed on specialty training at your organisation?
12. What additional support has been provided to your organisation to establish and accredit specialist training posts, health settings or networks?
13. Have you had training posts, health settings or a network your organisation is involved in de-accredited /disaccredited? Why? How did the college/s support the organisation to remediate and regain accreditation?
14. Does your organisation evaluate the performance of specialty medical training posts? How?
15. How much involvement has the Regional Training Hub in your region had in supporting your organisation with specialist medical college accreditation?
16. Is there a role for increased involvement of the Regional Training Hubs in accreditation of specialty training? If so, how?

Appendix N4: Regional Training Hubs

Face to Face Consultation Questions

1. What do you think are the challenges within the current specialist medical college accreditation frameworks in terms of how accreditation impacts on the development of non-metropolitan specialist training pathways? What is the biggest challenge impacting your organisation?
2. What elements of the current specialist medical college accreditation frameworks are working well? What are the key components that are critical to maintaining quality training and patient safety that need to be maintained into the future?
3. How could specialist medical college accreditations frameworks be improved for better geographical distribution of specialist medical training and in specialities that communities need?
4. What are the key activities for your organisation during an accreditation process (pre-application, application, assessment and decision)? What resources are required and how long does each stage usually take?
5. Do you have examples of new rural training sites successfully accredited and /or proposals that were not supported or need further work to meet the accreditation requirements?
6. How do you think your organisation can contribute to delivering more high quality regionally based medical specialist training, within the existing accreditation system?
7. How are government programs being used by your organisation to support the creation of new rural medical specialist training sites? Which programs are you participating in apart from Commonwealth programs?
8. If your organisation is involved in accreditation activities across the medical education and training continuum (medical school, prevocational and vocational training) can you think of any frameworks and/or practices that exist which streamline work and create efficiency and consistency in accreditation practices?
9. Has the Regional Training Hub had any involvement in specialist medical college accreditation for specialty training?
10. What barriers (if any) have been encountered in supporting the establishment of non-GP specialty training posts / sites / networks with specialist medical colleges?
11. Can you provide examples of specialist training models for your region? Were these accredited by specialist colleges?
12. Can you provide examples of successful partnerships, arrangements or collaborations in expanding specialist medical training to rural and regional Australia?



Appendix N5: Peak Bodies

Face to Face Consultation Questions – AMA Council of Doctors in Training

1. Are representatives of the AMA Council of Doctors in Training directly involved in specialist medical college accreditation of training posts / settings / networks? How?
2. What do you think are the challenges within the current specialist medical college accreditation frameworks in terms of how accreditation impacts on the development of non-metropolitan specialist training pathways? What is the biggest challenge impacting your organisation?
3. What elements of the current specialist medical college accreditation frameworks are working well? What are the key components that are critical to maintaining quality training and patient safety that need to be maintained into the future?
4. How could specialist medical college accreditations frameworks be improved for better geographical distribution of specialist medical training and in specialities that communities need?
5. What are the key activities for your organisation during an accreditation process (pre-application, application, assessment and decision)? What resources are required and how long does each stage usually take?
6. Do you have examples of new rural training sites successfully accredited and /or proposals that were not supported or need further work to meet the accreditation requirements?
7. How do you think your organisation can contribute to delivering more high quality regionally based medical specialist training, within the existing accreditation system?
8. If your organisation is involved in accreditation activities across the medical education and training continuum (medical school, prevocational and vocational training) can you think of any frameworks and/or practices that exist which streamline work and create efficiency and consistency in accreditation practices?

Face to Face Consultation Questions – Australian Medical Council (AMC)

1. What do you think are the challenges within the current specialist medical college accreditation frameworks in terms of how accreditation impacts on the development of non-metropolitan (rural) specialist training pathways? What is the biggest challenge for the AMC?
2. What elements of the current specialist medical college accreditation frameworks are working well? What are the key components that are critical to maintaining quality training and patient safety that need to be retained in future?
3. How could specialist medical college accreditation frameworks be improved for better geographical distribution of specialist medical training and in specialities that communities need?
4. What audit and quality improvement processes of accreditation activities are in place? For example to deliver change such as: flexibility, streamlining, innovation, collaboration, simplification and improve transparency?
5. How could the AMC contribute to delivering more high quality regionally based specialist medical training, within the existing accreditation system?
6. Can you think of any accreditation frameworks and/or practices that exist which could streamline work and create efficiency and consistency in specialist medical college accreditation practices?
7. In 2012 the Australian Health Ministers Advisory Council (AHMAC) led a project, *Accreditation of Specialist Medical Training Sites* in consultation with the colleges and the Council of Presidents of Medical Colleges. Has this project informed college accreditation frameworks and practices? How?
8. How does the AMC assess the efficacy of accreditation practices of specialist medical colleges?
9. Under Standard 8.2.2, following consultation with stakeholders, how does the AMC communicate with specialist medical colleges feedback on their performance in relation to accreditation of training posts, health settings and networks?
10. Under the National Law, one of the roles of the AMC is to support workforce distribution:
 - a. Do you think the current AMC accreditation standards, particularly as colleges apply them in the accreditation of specialty training, are able to fulfil this objective in relation to workforce distribution?
 - b. What changes would the AMC consider to progress further towards this?



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Face to Face Consultation Questions Medical Deans of Australia and New Zealand

1. Are Medical Deans Australia and New Zealand directly involved in specialist medical college accreditation of training posts, health settings and networks? How?
2. What do you think are the challenges within the current specialist medical college accreditation frameworks in terms of how accreditation impacts on the development of non-metropolitan (rural) specialist training pathways? What is the biggest challenge impacting your organisation, if any?
3. What elements of the current specialist medical college accreditation frameworks are working well? What are the key components that are critical to maintaining quality training and patient safety that need to be retained in the future?
4. How could specialist medical college accreditation frameworks be improved for better geographical distribution of specialist medical training and in specialities that communities need?
5. What are the key activities for your organisation during an accreditation process (pre-application, application, assessment and decision)? What resources are required?
6. Do you have examples of new rural training sites successfully accredited and /or proposals that were not supported or need further work to meet the accreditation requirements?
7. How do you think your organisation can contribute to delivering more high quality, regionally based specialist medical training, within the existing accreditation system?
8. If your organisation is involved in accreditation activities across the medical education and training continuum (medical school, prevocational and vocational training) can you think of any frameworks and/or practices that exist which streamline work and create efficiency and consistency in accreditation practices?

Appendix O: AMC Standards for Assessment and Accreditation

Standards for Assessment and Accreditation of Specialist Medical Programs and Professional Development Programs by the Australian Medical Council 2015²⁰⁸

Standard 8. Implementing the program – delivery of education and accreditation of training sites

8.1 Supervisory and educational roles

Accreditation standards

- 8.1.1 The education provider ensures that there is an effective system of clinical supervision to support trainees to achieve the program and graduate outcomes.
- 8.1.2 The education provider has defined the responsibilities of hospital and community practitioners who contribute to the delivery of the specialist medical program and the responsibilities of the education provider to these practitioners. It communicates its program and graduate outcomes to these practitioners.
- 8.1.3 The education provider selects supervisors who have demonstrated appropriate capability for this role. It facilitates the training, support and professional development of supervisors.
- 8.1.4 The education provider routinely evaluates supervisor effectiveness including feedback from trainees.
- 8.1.5 The education provider selects assessors in written, oral and performance-based assessments who have demonstrated appropriate capabilities for this role. It provides training, support and professional development opportunities relevant to this educational role.
- 8.1.6 The education provider routinely evaluates the effectiveness of its assessors including feedback from trainees.

Notes

The AMC recognises that the word ‘supervisor’ is used in the workplace to describe an administrative or managerial function equivalent to a line manager, but in this document it refers to supervision in the educational context.

Education providers will devise and implement their own structures in response to specific goals and challenges, but the following functions are common in the educational supervision of trainees. These functions may be combined in different ways and in large programs performed by a number of individuals:

- An individual with overall responsibility for the specialist medical program in a health service, training site or training network. This director oversees and ensures the quality of training and education rather than being involved on a day-to-day basis with all trainees in the work environment.

208 Standards for Assessment and Accreditation of Specialist Medical Programs and Professional Development Programs by the Australian Medical Council 2015, https://www.amc.org.au/wp-content/uploads/accreditation_recognition/specialist_edu_and_training/assessment/standards_for_assessment.pdf



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- Medical practitioners senior to the trainees who have day-to-day involvement with the trainee.
- An individual who has particular responsibility for the direct supervision and training of the trainee, whose involvement with that trainee during the working week is regular and appropriate for the trainee's level of training, ability, and experience.

Medical practitioners make significant contributions to medical education as teachers and role models for trainees. The educational roles of supervisor and assessor are critical to the success of the specialist medical program, especially as most specialist training is workplace-based. It is essential that there is adequate training and resources for these roles. Those filling supervisory roles should know the program requirements, and have skills in adult learning, in providing constructive feedback to trainees, and in responding appropriately to concerns. They need clear guidance on their responsibilities to the trainee and to patient safety in the event that the trainee is experiencing difficulty, including in circumstances where the trainee is not maintaining a satisfactory standard of clinical practice and/or is not meeting the expected fitness to practise standards.

All those who teach, supervise, counsel, employ or work with medical practitioners in training are responsible for patient safety. Patient safety will be protected through explicit and accountable supervision. Education providers should have clear and explicit supervision requirements, including processes for removing supervisors where necessary.

Other members of the health care team may also contribute to supervising, assessing and providing feedback to the trainee.

There are advantages for trainees to an ongoing mentoring relationship with a more senior medical colleague. This person has no formal role in the trainee's assessment or employment but can advise and support the trainee on personal or professional matters.

Education providers should encourage mentorship through a variety of their educational activities. They should also develop processes for supporting the professional development of medical practitioners who demonstrate appropriate capability for the role of mentor.

Because of the critical nature of the supervisory roles outlined above, it is essential that there are clear procedures for trainees and supervisors to follow in the event of conflict. Accreditation standards in relation to the resolution of training-related problems and disputes are provided under standard 7.5.

Assessors engaged in formative or summative assessments must understand the education provider's curriculum and training requirements, be proficient in the issues relating to the level of competence and training of the trainee, and skilled in providing feedback. Those assessing trainees should participate in training and education addressing issues such as constructive feedback, dealing with difficult situations and contemporary assessment methods.

8.2 Training sites and posts

Accreditation standards

- 8.2.1 The education provider has a clear process and criteria to assess, accredit and monitor facilities and posts as training sites. The education provider:
- applies its published accreditation criteria when assessing, accrediting and monitoring training sites
 - makes publicly available the accreditation criteria and the accreditation procedures
 - is transparent and consistent in applying the accreditation process.
- 8.2.2 The education provider's criteria for accreditation of training sites link to the outcomes of the specialist medical program and:
- promote the health, welfare and interests of trainees
 - ensure trainees receive the supervision and opportunities to develop the appropriate knowledge and skills to deliver high-quality and safe patient care, in a culturally safe manner
 - support training and education opportunities in diverse settings aligned to the curriculum requirements including rural and regional locations, and settings which provide experience of the provisions of health care to Aboriginal and Torres Strait Islander peoples in Australia and/or Maori in New Zealand

- ensure trainees have access to educational resources, including information communication technology applications, required to facilitate their learning in the clinical environment.

8.2.3 The education provider works with jurisdictions, as well as the private health system, to effectively use the capacity of the health care system for work-based training, and to give trainees experience of the breadth of the discipline.

8.2.4 The education provider actively engages with other education providers to support common accreditation approaches and sharing of relevant information.

Notes

Since training and education in most specialties takes place in health services, specialist medical training is a shared responsibility between the education providers and these training sites. The quality of the learning experience depends on the support the unit or service provides.

Education providers have formal processes to select and accredit training sites, and the process and requirements for accreditation vary depending on the medical specialty. Many commonalities exist between education providers' processes but so do inconsistencies. The AMC recognises the significant interest of training sites and education providers in ongoing quality improvements in and streamlining of these processes, including where relevant, greater sharing of information or processes between providers. The AMC endorses work to develop tools to support consistent approaches to accreditation, such as the Accreditation of Specialist Medical Training Sites Project.¹² The accreditation standards under 8.2.2 draw on the domains for accreditation in that report and education providers are encouraged to use these standards.

Education providers define the range of experience to be gained during training. Education providers should make as explicit as possible the expectations of training sites seeking accreditation, including clinical and other experience, education activities and resources, and expectations for flexible training options. Education provider accreditation processes must verify that this experience is available in training sites seeking accreditation and once accredited must evaluate the trainees' experience in those sites.

The accreditation process should result in a report to the training site. Where accreditation criteria are not met, the report should give guidance so that the training site may address any unmet requirements.

Trainees are likely to gain experience in multiple locations each providing a varying range of experiences of the specialist discipline. For this reason, education providers are increasingly accrediting networks of training sites rather than expecting a single training site to provide all the required training experience, and while all training sites should satisfy the education provider's accreditation criteria, the AMC encourages flexible rather than restrictive approaches that enable the capacity of the health care system to be used most effectively for training.

¹² Australian Health Ministers' Advisory Council Health Workforce Principal Committee, *Accreditation of Specialist Medical Training Sites Project Final Report*, 2013



Appendix P: References

General

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